SEATTLE CITY COUNCIL

Public Safety and Human Services Committee

Agenda

Tuesday, September 22, 2020

9:30 AM

Remote Meeting. Call 253-215-8782; Meeting ID: 586 416 9164; or Seattle Channel online.

Lisa Herbold, Chair
M. Lorena González, Vice-Chair
Andrew J. Lewis, Member
Tammy J. Morales, Member
Kshama Sawant, Member
Alex Pedersen, Alternate

Chair Info: 206-684-8801; Lisa.Herbold@seattle.gov

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SEATTLE CITY COUNCIL

Public Safety and Human Services Committee

Agenda

September 22, 2020 - 9:30 AM

Meeting Location:
Remote Meeting. Call 253-215-8782; Meeting ID: 586 416 9164; or Seattle Channel online.

Committee Website:
http://www.seattle.gov/council/committees/public-safety-and-human-services

This meeting also constitutes a meeting of the City Council, provided that the meeting shall be conducted as a committee meeting under the Council Rules and Procedures, and Council action shall be limited to committee business.

In-person attendance is currently prohibited per Washington State Governor's Proclamation No. 20-28.9, through October 1, 2020. Meeting participation is limited to access by telephone conference line and Seattle Channel online.

Register online to speak during the Public Comment period at the 9:30 a.m. meeting at http://www.seattle.gov/council/committees/public-comment.

Online registration to speak at the 9:30 a.m. meeting will begin two hours before the 9:30 a.m. meeting start time, and registration will end at the conclusion of the Public Comment period during the meeting. Speakers must be registered in order to be recognized by the Chair.

Submit written comments to Councilmember Herbold at Lisa.Herbold@seattle.gov
Sign-up to provide Public Comment at the meeting at http://www.seattle.gov/council/committees/public-comment
Watch live streaming video of the meeting at http://www.seattle.gov/council/watch-council-live
Listen to the meeting by calling the Council Chamber Listen Line at 253-215-8782 Meeting ID: 586 416 9164
One Tap Mobile No. US: +12532158782,,5864169164#

Please Note: Times listed are estimated

A. Call To Order

B. Approval of the Agenda

C. Public Comment

(15 minutes)

D. Items of Business

1. Appt 01638 **Appointment of Dorothy Yee Leggett as member, Public Safety Civil Service Commission, for a term to December 31, 2022.**

Attachments: Appointment Packet

Briefing, Discussion, and Possible Vote (10 minutes)

Presenters: Andrea Scheele, Executive Director, Public Safety Civil Service Commission; Newell Aldrich, Councilmember Herbold's Office

2. Appt 01639 **Appointment of Catherine Marie McDowall as Seattle Municipal Court Judge, Position 1.**

Attachments: Appointment Packet
Judicial Committee Letter of Support

Briefing, Discussion, and Possible Vote (10 minutes)

Presenters: Michelle Chen, Mayor's Office; Presiding Judge Willie Gregory, Seattle Municipal Court

3. CB 119893 **AN ORDINANCE relating to the Seattle whistleblower protection code; expanding the definition of "report" in the City of Seattle's whistleblower protection ordinance to include reporting to the Office of Inspector General for Public Safety; amending Section 4.20.805 of the Seattle Municipal Code.**

Supporting Documents:
Summary and Fiscal Note
Central Staff Memo

Briefing, Discussion, and Possible Vote (15 minutes)

Presenters: Amy Tsai and Mary Dory, Office of Inspector General; Wayne Barnett, Director, Seattle Ethics and Elections Commission; Lish Whitson, Council Central Staff

4. **An analysis of court imposed monetary sanctions in Seattle Municipal Courts**

Supporting Documents:
Memo - Monetary Sanctions Report
Report - Analysis of Court Imposed Monetary Sanctions In Seattle Municipal Courts
Presentation

Briefing and Discussion (15 minutes)

Presenters: Caedmon Cahill, Office for Civil Rights; Dr. Alexes Harris, University of Washington; Dr. Frank Edwards, Rutgers University

5. **Community Service Officer Program Implementation**

Supporting Documents:
SPD Report on Community Service Officer (CSO) Program Implementation (SLI 11-A-1)

Briefing and Discussion (20 minutes)

Presenters: Adrian Diaz, Interim Chief of Police; Stephen Hirjak, Assistant Chief, Seattle Police Department

6. **Supervised Consumption Presentation**

Supporting Documents:
Final Heroin Opiate Addiction Task Force Report
Project Description for Supervised Consumption
Presentation - Seattle - King County Public Health
Presentation - Yes to SCS

Briefing and Discussion (20 minutes)

Presenter: Brad Finegood, Seattle-King County Public Health; Dr. Richard Waters, Neighborcare; Jesse Rawlins, Public Defender Association; Mark Cooke, American Civil Liberties Union of Washington; Michael Ninburg, Executive Director Hepatitis Education Project; Lisa Etter-Carlson, Co-Founder of Aurora Commons

7. **Co-LEAD Presentation**

Supporting Documents:
Presentation

Briefing and Discussion (20 minutes)

Presenters: Jesse Benet, Public Defenders Association; Tabatha Davis and Ramon Hernandez, Co-LEAD; Forrest Stuart, Associate Professor of Sociology, Stanford; Katherine Beckett, Chair, Department of Law, Societies and Justice, University of Washington

E. Adjournment

Legislation Text

File #: Appt 01638, **Version:** 1

Appointment of Dorothy Yee Leggett as member, Public Safety Civil Service Commission, for a term to December 31, 2022.

The Appointment Packet is provided as an attachment.

City of Seattle Boards & Commissions Notice of Appointment

Appointee Name: *Dorothy Yee Leggett*		
Board/Commission Name: *Public Safety Civil Service Commission*		**Position Title:** *Member*
☒ **Appointment** ***OR*** ☐ **Reappointment**	**City Council Confirmation required?** ☒ Yes ☐ No	
Appointing Authority: ☒ City Council ☐ Mayor ☐ Other: *Fill in appointing authority*	**Term of Position: *** 1/1/2020 **to** 12/31/2022 ☒ *Serving remaining term of a vacant position*	
Residential Neighborhood: *Meadowbrook*	**Zip Code:** *98125*	**Contact Phone No.:** [redacted]
Background: *Dorothy Yee Leggett has a wide variety of legal and policy experience at the federal, state and local levels, in areas including worker's compensation law, family law, and non-profit governance. She serves as staff attorney for the Eastside Legal Assistance Program, and assists survivors of domestic violence, hosts legal clinics, and advises clients on issues including employment, housing, public benefits, immigration and family law. As Staff Counsel to the California State Compensation Insurance Fund she conducted investigations and legal research of state regulations and case law, and made over 500 appearances before the Worker's Compensation Appeals Board. She served as a Policy Analyst in the United States Government Accountability Office on a numerous of issues, including best practice case studies and performance measurement standards. She has a J.D from Loyola Law School, and a Master of Public Policy degree from The College of William and Mary. She has volunteered for the Center for Children & Youth Justice, HIV & AIDS Legal Services Alliance, the Children's Rights Project, Families of Color Seattle, and the King County Bar Association.*		
Authorizing Signature (original signature):  **Date Signed (appointed):** 9-14-2020	**Appointing Signatory:** *Councilmember Lisa Herbold* *Chair, Public Safety and Human Services Committee*	

**Term begin and end date is fixed and tied to the position and not the appointment date.*

Dorothy Yee Leggett, Esq.

[redacted]

Skill & Experience Highlights

- An attorney with extensive legal & policy experience in:

  State & Federal Government *Worker's Compensation Law*
  Family Law *Non-Profit Governance*

- Tackles case management with an analytical mindset to identify problems and potential solutions
- Nimble and thrives in dynamic and fast-paced environments
- Strong project ownership and commitment to team goals
- Detail-oriented and highly organized with strong written and oral communication skills

Selected Accomplishments

- Managed a collaborative Medical-Legal Partnership at multiple Federally Qualified Health Centers across King County.
- Negotiated settlements for hundreds of cases that saved California State Compensation Insurance Fund millions of dollars in potential worker's compensation injury rewards
- Wrote sections of seven published U.S. Government Accountability reports for members of Congress and Congressional Committee staff regarding federal infrastructure and security
- Made recommendations to Congress to streamline government operations, potentially saving taxpayers millions of dollars
- Co-led efforts for Families of Color Seattle to establish its 501(c)(3) nonprofit status and wrote its bylaws, conflict of interest policies, and compensation policies
- Part of the team that led the landmark litigation by California against U.S. tobacco companies to eliminate youth-targeted advertising

Professional Experience

Staff Attorney 2018-current
Eastside Legal Assistance Program Bellevue, WA

- Assisted survivors of domestic violence with drafting of court pleadings and legal representation during the Protection Order process and divorce and child custody cases.
- Managed a Medical-Legal Partnership (MLP) program and hosted legal clinics at several community health centers in the region.
- Advised MLP clients on a variety of civil legal aid issues including employment, housing, public benefits, immigration, and family law issues.

Solo Practitioner 2012-18
Law Office of Dorothy Yee Leggett Seattle, WA

- General part-time civil litigation and family law practice including pro-bono case management
- Legal research and document review; drafting of legal memorandum and pleadings on civil cases
- Represent clients in court hearings and prepared motions and petitions for contested divorce and child custody cases, nonparental custody, and individuals with special immigrant juvenile status

Staff Counsel 2007-11
California State Compensation Insurance Fund (SCIF) Glendale, CA

- Represented SCIF in administrative hearings, trials, and settlement conferences, and made over 500 appearances before the Worker's Compensation Appeals Board
- Provided legal consultation to Claims Department personnel and employer clients
- Reviewed medical and employment records and deposed injured workers, treating physicians, and medical examiners
- Conducted investigations and legal research of state regulations and case law
- Prepared trial briefs and Petitions for Reconsideration for cases appealed to the Board

Policy Analyst 2002-07
United States Government Accountability Office (GAO) Los Angeles, CA & Washington D.C.

- Researched and conducted audit work for the independent, investigative arm of Congress on issues including contract procurement, transportation, federal court facilities, and Social Security
- Drafted reports by reviewing state and federal statutes and regulations, conducting interviews with government and private sector officials, and collaborating with economists and research methodologists
- Employed a variety of research methodologies including statistical analysis, best practices case studies, and performance measurement standards

Associate Governmental Program Analyst 1999-2000
California Department of Health Services, Medi-Cal Managed Care Division Sacramento, CA

- Analyzed state and federal statutes, legislation, and regulations related to Medi-Cal managed care
- Researched policy-related program, procedural, and operational issues
- Wrote policy letters and health plan correspondence, amendments to contract language, briefing papers, and response points for the Division chief

Staff Services Analyst 1998-99
California Department of Justice, Tobacco Litigation Section Sacramento, CA

- Worked alongside a team of attorneys to review defendant and plaintiff's documents during the discovery phase of the state's litigation case against the tobacco industry
- Analyzed evidentiary materials and prepared memoranda and case reports

Education

Juris Doctorate — 2006
Loyola Law School — Los Angeles, CA

Master of Public Policy — 2002
The College of William & Mary — Williamsburg, VA

Bachelor of Arts, Political Science (Public Service) & Biology — 1998
University of California, Davis — Davis, CA

Internships & Externships

Los Angeles City Attorney's Office—Housing Enforcement Unit — 2006

California Department of Justice—Employment, Regulation & Administration — 2004-05

Loyola Law School Center for Conflict Resolution — 2004-05

White House Office for Women's Initiatives and Outreach — 1997

Awards

"Rising Star," Southern California Super Lawyers — 2009

Board of Advisors Award for Outstanding Graduate Student, The College of William & Mary — 2002

Citation for Outstanding Performance in Political Science, University of California, Davis — 1998

Memberships

King County Bar Association — 2012-present

Washington State Bar Association — 2012-present

California State Bar Association — 2006-present

American Bar Association — 2003-16

Tort, Trial, and Insurance Practice Section (TIPS) Fellow
TIPS Outreach to Young Lawyers Committee
Minorities in the Profession Scholar, Young Lawyers Division

Los Angeles County Bar Association — 2005-11

Professional Volunteer Activities

Vice President & Board Member, Families of Color Seattle 2014-18

- Assist an emerging nonprofit with 501(c)(3) charity formation, nonprofit governance, grant applications, program development and fundraising.

Attorney, King County Bar Association 2012-18

- Represented clients involved in contested divorce, parenting plan, and nonparental custody cases through settlement in the Family Law Mentorship Program and the Kinship Care Solutions Program.

Attorney, Center for Children & Youth Justice 2012-18

- Represented former foster care youth seeking legal assistance in family law cases.

Attorney, HIV & AIDS Legal Services Alliance 2007-11

- Represented clients facing creditor / debtor issues. Counseled clients and negotiated payment plans and / or forbearance with creditors.

Public Counsel, Children's Rights Project 2007-11

- Served as guardian ad litem on behalf of a minor child on a tort case that settled for $1.6 million. Attended mediation sessions and settlement conference.

Public Safety Civil Service Commission

3 Members: Pursuant to SMC 4.08.250, 1 member subject to City Council confirmation, 3-year terms:

- 1 City Council- appointed
- 1 Mayor- appointed
- 1 Other Appointing Authority: Employee Elected

Roster:

*D	**G	RD	Position No.	Position Title	Name	Term Begin Date	Term End Date	Term #	Appointed By
1	F	5	1.	Commissioner	Dorothy Yee Leggett	1/1/20	12/31/22	1	City Council
6	M	1	2.	Commissioner	Joel Nark	1/1/18	12/31/20	7	Employee Elected
6	F	1	3.	Commissioner	Stacy Connole	1/1/19	12/31/21	3	Mayor

SELF-IDENTIFIED DIVERSITY CHART	(1) Male	(2) Female	(3) Transgender	(4) NB/ O/ U	(5) Asian	(6) Black/ African American	(7) Hispanic/ Latino	(8) American Indian/ Alaska Native	(9) Other	Caucasian/ Non-Hispanic	Pacific Islander	Middle Eastern	Multiracial
Mayor		1								1			
Council		1			1								
Other	1									1			
Total	1	1								2			

Key:

***D** List the corresponding *Diversity Chart* number (1 through 9)
****G** List *gender*, **M**= Male, **F**= Female, **T**= Transgender, **NB=** Non-Binary, **O=** Other, **U**= Unknown
RD Residential Council District number 1 through 7 or N/A

Diversity information is self-identified and is voluntary.

Legislation Text

File #: Appt 01639, **Version:** 1

Appointment of Catherine Marie McDowall as Seattle Municipal Court Judge, Position 1.

The Appointment Packet is provided as an attachment.

City of Seattle

Judge
Seattle Municipal Court

Confirmation Packet
September 16, 2020

Catherine Marie McDowall

City of Seattle
Mayor Jenny A. Durkan

September 16, 2020

The Honorable Lorena González
President, Seattle City Council
Seattle City Hall, 2nd Floor
Seattle, WA 98104

The Honorable Lisa Herbold
Chair Public Safety Committee, Seattle City Council
Seattle City Hall, 2nd Floor
Seattle, WA 98104

Dear Council President González and Chair Herbold:

I am pleased to present to the City Council the confirmation packet for Catherine McDowall, who is my appointment to fill the vacancy on the Seattle Municipal Court, Position 1. Ms. McDowall is being appointed to fill the position previously held by Judge Edward McKenna, who retired in April of this year.

Please find attached a confirmation packet that includes the following:

1. Ms. Catherine Marie McDowall notice of appointment;
2. her oath of office;
3. her application materials and questionnaire; and
4. supplemental materials Ms. Catherine McDowall offered in support of her appointment.

Ms. Catherine McDowall currently serves as Judge Pro Tempore on the Seattle Municipal Court, and has served in that role since 2013. Judge Pro tem McDowall received her undergraduate degree from Northwestern University in Evanston, Illinois, then attended the University of Virginia School of Law for her Juris Doctorate. She began her career in private practice doing civil litigation in Washington, DC before moving to Seattle where she joined the King County Prosecuting Attorney's Office as a deputy prosecutor in 1998 and was promoted to Senior deputy prosecutor. She has 22 years of courtroom trial experience working on all types of criminal cases from misdemeanors to felonies, and at all levels from filing to appeals.

Judge Pro tem McDowall is well respected by the current judiciary and she has demonstrated experience and knowledge of the law and the challenges facing the court. She understands the criminal justice reforms the court is currently implementing and she has a deep commitment to addressing the issues of systemic and institutional racism as demonstrated by her support for more diversion programs, addressing jury selection and bias, as well as the implementation of changes to probation. Further, her reputation as a judicial officer is she exhibits the highest integrity handling each case with fairness and impartiality and showing empathy and respect for all those who enter her courtroom.

Judge Pro tem McDowall received a well qualified rating from the King County Bar Association. Further, the Mayor conducted a Judicial Evaluation Committee process pursuant to ordinance 121698, which was

comprised of representatives from the Minority Bar Associations, City Attorney's Office and the Public Defender Association. The Judicial Evaluation Committee recommended Judge Pro Tem McDowall for appointment to the Seattle Municipal Court.

If you have any questions about the attached materials or need additional information, please contact Michelle S. Chen, Legal Counsel to the Mayor at 684-5452.

Sincerely,

Jenny A. Durkan
Mayor of Seattle

City of Seattle Boards & Commissions Notice of Appointment

Appointee Name: *Catherine Marie McDowall*		
Board/Commission Name: *Seattle Municipal Court*		**Position Title:** *Judge*
☒ **Appointment** ***OR*** ☐ **Reappointment**	**City Council Confirmation required?** ☒ Yes ☐ No	
Appointing Authority: ☐ City Council ☒ Mayor ☐ Other:	**Term of Position:** Confirmation **to** 12/31/2022 ☒ *Serving remaining term of a vacant position*	
Residential Neighborhood: *Magnolia*	**Zip Code:** *98199*	**Contact Phone No.:** [redacted]

Background:

Ms. Catherine McDowall is currently serving as Judge Pro Tempore at Seattle Municipal Court. She has been in a judicial officer role for the last seven years since 2013 and before that she was Senior Deputy Prosecutor in the King County Prosecuting Attorney's Office. As Pro Tem Judge, Ms. McDowall has demonstrated her skills as a judicial officer who has presided over different calendars and specialty courts: Mental Health court, Community court, and Veteran's court. She is exceptionally well qualified to join the bench given her familiarity with the court's procedures and personnel and can transition seamlessly into the role and deal with the court's high volume and backlog of cases. More importantly, Pro Tem Judge McDowall is knowledgeable about the court's current reform efforts and she is deeply committed to innovation and addressing systemic racism in the criminal justice system. She was rated Well Qualified by the King County Bar Association and Qualified by the Loren Miller Bar Association.

Authorizing Signature (original signature): Jenny A. Durkan **Date Signed (appointed):** 9/16/2020	**Appointing Signatory:** *Jenny A. Durkan* *Mayor, City of Seattle*

CITY OF SEATTLE - STATE OF WASHINGTON
OATH OF OFFICE

STATE OF WASHINGTON

COUNTY OF KING

"I do solemnly swear (or affirm) that I will support the Constitution of the United States and the Constitution of the State of Washington, and that I will faithfully discharge the duties of the office of judge of the Municipal Court of The City of Seattle according to the best of my ability."

_____
Catherine Marie McDowall

Subscribed and sworn to before me (affix seal)
this _____ day of _____, 2020

_____
Monica Martinez Simmons, City Clerk

City of Seattle
Judicial Evaluation Questionnaire

This questionnaire is confidential and will be used to facilitate the recommendation of candidates for the Seattle Municipal Court vacancy.

Instructions: Please answer the following questions in the space provided or on an attachment. The original questionnaire should be sent to JudicialVacancy@seattle.gov. If you have questions, please telephone the City Clerk's office at 206.684.8344.

1. First Name: Catherine
Middle Name: Marie
Last Name: McDowall

2. Home Address: [redacted]
City: Seattle
State: WA
Zip: 98199

3. Business Address: [redacted]
City: Seattle
State: WA
Zip: 98199

4. Date of Birth: [redacted]
Place of Birth: Willoughby, Ohio

5. Years of admission to practice law? 25
In Washington? 23

6. List colleges and universities attended, years of attendance, degree awarded and reason for leaving if no degree was awarded.

Northwestern University, 1987-1991, BA Political Science, BA Slavic Studies

7. List law schools attended, years of attendance, degree awarded and reason for leaving if no degree was awarded.

University of Virginia School of Law, 1992-1995. JD

8. Provide the following information concerning your legal experience:

A. If a practicing lawyer, the general nature of your current and past law practice and identify the firms or companies with whom you have worked:

Currently, I am practicing law exclusively as a Pro Tem Judge in Seattle Municipal Court (since October 2013), King County District Court (since April 2016), and King County Superior Court – Juvenile Division (since February 2015).

From 1998-2009, I worked as a Deputy Prosecuting Attorney (Senior Deputy Prosecuting Attorney from 2003-2009) in the Criminal Division of the King County Prosecutor's Office. I served in the District Court Unit, Juvenile Court Unit, Felony Trial Teams, Early Plea Unit and Appellate Unit. From 2003-2009 I worked exclusively in the Appellate Unit, arguing cases before Division One Court of Appeals and the Washington Supreme Court.

Prior to moving to Seattle, I worked for Sonnenschein, Nath and Rosenthal (now Dentons) as a litigation associate in the Washington, D.C. office, from 1995 through 1997.

B. If a judicial officer, the court on which you serve, the dates of service, and your prior experience practicing law, including information responsive to 8(a) above:

N/A

C. If you are neither a practicing lawyer nor judicial officer, describe with particularity the nature and extent of your legal experience.

N/A

9. List all courts and jurisdictions in which you have been admitted to practice and the date of admission. Give the same information for administrative bodies having special admission requirements.

- Virginia State Bar, 1995-1997.
- Washington, D.C. Bar, 1995-1997.
- Washington State Bar, 1997-present.

10. Are you in good standing in every bar association of which you are a member? If not, please explain.

Yes.

11. Describe five of the more significant matters that you have handled and give the citation if the cases were reported.

- City of Seattle v. Barnes, et al, No. 638607. March 2019. I presided over a pretrial motion hearing in this case that joined twelve defendants who were charged with crimes relating to protests in the downtown core in two separate incidents. The case involved six discrete legal motions on First Amendment grounds, sufficiency of the evidence (*Knapstad)*, Sixth Amendment grounds *(Apprendi)*, prosecutorial vindictiveness and other issues. After the hearing, I issued a written ruling on the consolidated motions. (Copy attached.)

- City of Seattle v. Bulene, Howell and Jarvinen, Nos. 598935, 598936, 598937. In one of the first cases I handled as a Pro Tem Judge, I presided over this multi-defendant jury trial, which lasted over a period of several weeks in November-December 2014. The case involved a significant amount of publicity, because two of the defendants were Seattle Fire Department employees, who were charged with assaulting a homeless man near the fireman's memorial in Occidental Park after a Sounders game.

- State v. Athan, 160 Wn.2d 354 (2007). Lead opinion written by Justice C. Johnson. This case was significant because of the novel legal issues presented, particularly with respect to the initial sample of DNA obtained from the defendant. Police used a ruse and sent the defendant a letter requesting a response. The defendant licked the envelope, thus unwittingly providing a sample of his DNA. Several amicus curiae, including the ACLU and WSBA, filed hundreds of pages of briefing. I was the sole attorney representing the State on appeal in this case.

- State v. Ahluwalia, 143 Wn.2d 527 (2001). Lead opinion written by Justice J. Smith. This case was significant because it was my first case before the Washington Supreme Court. I served as sole counsel for the State on appeal, arguing double jeopardy issues related to proceedings after an acquittal on one charge but a hung jury on the lesser charge.

- State v. Lorenzo Marr, King County Case No. 00-1-11267-6 SEA. Jury trial in October-November 2001 before Judge Helen Halpert. This trial, which I also handled as sole trial counsel for the State, involved the prosecution of this defendant for multiple counts of Possession of Stolen Property. The case generated significant publicity, due to the defendant's relationship to a murder suspect who was at large when the searches of the house were conducted. The case involved complicated issues of proof related to the value of the items seized.

12. If you have had any other experience in the legal profession that you believe enhances your qualifications for serving as a trial judge, briefly describe it here.

Between college and law school, I lived in the Washington, D.C. area and worked as a legal assistant in a large law firm. Although I supported a number of attorneys in various practice areas in the office, I was assigned primarily to support a lawyer who served as a lobbyist for a natural gas association. This assignment required me to attend and summarize a number of Congressional hearings on topics of interest to our clients. I also coordinated and prepared a briefing packet for the periodic meetings of the association members. This experience gave me an insight into our federal political processes and also into the planning and strategizing that lobbyists and politicians do to influence government institutions and agencies on behalf of special interests.

13. Describe your experience or interactions, both personally and professionally, with individuals from different racial, ethnic, religious or cultural backgrounds than your own. Please describe efforts you have made in order to promote diversity in your professional and personal activities and to assure equal access to the law for all individuals.

I was raised in a largely white, middle class suburb in Ohio. After leaving that suburb to attend college in another state, and in a very urban environment (Chicago), I became acquainted with a number of people from different racial, ethnic, religious and cultural backgrounds, as well as people from other states and countries, and I became friends with a number of people of color. Between college and law school I lived in the Washington, D.C. area, and was exposed to many different cultures. While attending law school in the southern state of Virginia, I was exposed to even more people of color, in particular, several people of color who grew up and lived in the south, and I became friends with a number of people of color during that time as well.

From 1999-2011, my husband served on the Board of Directors of The ARC of King County. The ARC advocates for and supports the civil rights of children and adults with intellectual and developmental disabilities in our region. Through his contact with this agency and our involvement with fundraising activities for the agency, I came into contact with people with developmental disabilities and learned a great deal of information about issues related to their needs, such as housing and job training. My husband continues to serve on the finance committee since leaving the Board of Directors, and we remain involved in their fundraising efforts.

Professionally, while serving as a prosecuting attorney and as a Pro Tem judge, I have been exposed to a wide variety of people from diverse backgrounds, as colleagues, witnesses, victims, and defendants. In particular, while serving as a deputy prosecutor in juvenile court, I recall discovering in excruciating detail the heartbreaking social and personal history of many respondents and victims. Much of this exposure came through reading the very detailed reports from the Juvenile Probation Counselors who were assigned to supervise juveniles who enter that system as offenders. Additionally, I had personal contact with similarly situated individuals who were victims and witnesses of

the alleged crimes, including recent immigrants and people with very different personal histories than what I have personally experienced. Those months serving King County in juvenile court were some of the most impactful experiences I had as a prosecutor, broadening my world view in ways that made me more aware of, and compassionate toward, people with life experiences so drastically different from my own. This experience also cemented my commitment to public service.

More recently, I have attended a number of training sessions and CLE programs related specifically to diversity in the legal profession and addressing social justice issues. For example, I have attended CLE presentations on the impact of microaggressions, the proposed reform of jury selection to prevent racial bias, addressing generational differences in the legal profession and the consequences of mass incarceration trends in Washington State. On a personal level, I have tried to educate myself about racial and social justice issues through reading non-fiction and fiction books, watching documentaries and through other media, such as news programs and podcasts. I strive to continually educate myself, to learn and listen to people with vastly different perspectives and personal views, and to reevaluate and examine my beliefs and opinions in light of new information that I receive.

14. Have you ever served as a judicial officer or sought appointment or election to a judicial office? If so, give the details, including the courts involved, whether elected or appointed, and the periods of service. Include service as a pro-tem judge, giving courts, approximate dates, and names, addresses and telephone numbers of various attorneys who appeared before you.

A. Pro Tem Judge, Seattle Municipal Court, October 2014 – present. The following list contains the names of some attorneys who have appeared before me in trials:

- *City of Seattle v. Jose Mercado Guzman, No. 645066, DUI, trial in September, 2019.*
  - Assistant City Attorney: Gorry Sra, [redacted]
  - Defense Attorney: Sara Mendes, [redacted]

- City of Seattle v. Sharde Sheperd, No. 613566, Assault, trial in October, 2016.
  - Assistant City Attorney: Phillip Chu, now with Weinstein Caggiano, PLLC, [redacted]
  - Defense Attorney: Sade Smith, Smith Law LLC, [redacted]

- *City of Seattle v. Adelyn Rostomily, No. 601551, DUI, trial in October, 2015.*
  - Assistant City Attorney: Barbara Serrano, now with Washington Attorney General's Office, [redacted]

- Defense Attorney: Kevin Trombold, [redacted]

- While serving in Seattle Municipal Court, many attorneys appear before me for very short hearings. The following lawyers have appeared before me as counsel in recent cases with substantive motions or longer criminal calendars:
  - Danielle Malcolm, [redacted]
  - Neil Fox, Law Office of Neil Fox, PLLC, [redacted]
  - Francisco Duarte, Fury Duarte, PS, [redacted]
  - Dan Okada, [redacted]

B. Pro Tem Judge, King County District Court, April 2016 – present. The following list contains the names of some attorneys who have appeared before me in trials:

- *State v. Keyse Yousef, No. 516063810, Assault, trial in November, 2017.*
  - DPA: Matthew Gross, [redacted]
  - Defense Attorney: Jennifer Kaplan, [redacted]

- *State v. Edward Cale, No. 9Z0013876, DUI, trial in February, 2020.*
  - DPAs: Armando Padron-Cruz, [redacted] and Steve Herschkowitz, [redacted]
  - Defense Attorney: David O, [redacted]

C. Pro Tem Judge, King County Superior Court Juvenile Division, February 2015 – present. I have not presided over any trials at juvenile court, nor have I presided over any substantive motions. The last time I served as a Pro Tem in this court was March, 2019.

15. Have you ever held public office other than a judicial office, or have you ever been a candidate for such an office? If yes, give the details, including the offices involved, whether elected or appointed, and the length of your service.

No.

16. Have you ever been arrested, charged or held by federal, state, or other law enforcement authorities for violation of any federal law, state law, county or municipal law, regulation or ordinance? If yes, please give details. (Do not include

traffic violations for which a fine of $150.00 or less was imposed.) If any such episode occurred, you may give your view of how it bears on your present fitness for judicial office.

No.

17. Has a client, lawyer or other party ever brought a claim or suit against you for malpractice or filed a complaint or other grievance against you with a bar association or other entity or organization charged with investigating claims of professional misconduct, including organizations charged with overseeing judicial conduct? If yes, please give particulars and the results.

No.

18. Have you ever been a party or otherwise involved in any other legal proceedings? If yes, give the particulars. Do not list proceedings in which you were merely a guardian ad litem or stakeholder. Include all legal proceedings in which you were a party in interest.

- Case No. 20-2-03510-6 SEA, John McDowall and Catherine McDowall v. William A. Oberg, dba Oberg Build+Design and or/ dba Veritas Build + Design, Western Surety Company and Wesco Insurance Company. This is a breach of contract dispute over the construction of a garage on our home property.

- Case No. 10-2-04607-1 SEA, J.M. and C.M. v. John Does 1 to 2. This was a tort/defamation claim against an unknown person or persons who distributed false and defamatory information about my husband, we believed connected with a litigation matter he was handling as a private attorney. The identity of the perpetrators was never confirmed, and we ultimately dismissed the suit.

19. Are you aware of anything in your background or any event you anticipate in the future that might be considered to conflict with an appointment to the Seattle Municipal Court bench?

No.

20. Are you now or have you ever been a member of an organization or club which excludes persons from membership on the basis of race, national origin, gender, sexual orientation, disability, or religion? If yes, please explain, and include in your answer any actions you undertook to change such policies.

No.

21. List any non-legal activities in which you have been involved that enhance your qualifications for the municipal bench, whether civic, charitable, or otherwise. Also list any military service, giving branch, rank, dates of service, and type of discharge.

I am an active member of Our Lady of Fatima Parish and School, Seattle, WA. I currently serve as a member of the Pastoral Council (providing the Pastor with advice and guidance on parish administration). From 2016-2018, I served on the School Commission, advising the school principal on school budget and other issues. From 2002 – 2016, I volunteered as a member of the Magnolia Moms group at our church. This group was a charitable organization focused on supporting women's and children's charities in our community. For three years, I co-chaired the Magnolia Moms Winter Coat Drive that provided hundreds of coats to these charities. I also volunteered as a Religious Education Catechist from 2001-2013, teaching religion to first grade students in our parish.

I served on the board of the Magnolia Little League from 2013-2018. During that time, I was the Vice President, Softball Division. Under my leadership, the softball program grew from 50 participants to 130 participants during a three-year period, making it the second largest program in the City of Seattle. I was instrumental in developing a new division in the city-wide district that promoted the development of younger players in the league. Additionally, I served as an assistant coach for tee-ball and softball teams during the 2012-2014 seasons.

22. State those qualities that you consider to be most important in a person holding judicial office.

Judicial officers should above all else act with integrity, fairness, and compassion. All people have implicit bias and view cases through the lens of their own personal experience. Judges should be particularly aware of their implicit biases, and work to counteract those biases as they rule on issues before them. Judges should also be able to listen to opposing arguments with an open mind and a willingness to change their mind on any given issue. Judges must also be well versed in the law, and must be willing to take the time to research and study issues raised in the cases before them.

23. State your reasons for seeking appointment to the municipal court bench. Include those qualities you possess that you list in question 22.

I am seeking this judicial appointment because I believe our city and state courts need experienced, fair judges who will keep an open mind about issues before them, and who will aspire to make sound legal rulings free from implicit bias or political influence. My extensive experience in criminal appellate practice makes me uniquely qualified to make such decisions, including decisions related to novel legal issues.

I aspire to be a fair judge who accurately applies the law to cases before me with compassion, kindness, and sound legal reasoning. I want to promote faith and confidence in our judicial system, through my contact with lawyers, defendants, jurors and all court

staff. I intend to promote civility among advocates, provide a bridge between the courts and other branches of government, and continue to raise the level of practice in our local courts.

My experience over the past seven years as a Pro Tem Judge in several jurisdictions, as well as my prior experience as an advocate in Superior Court and in the appellate courts, has prepared me well for a full-time position as a Municipal Court Judge, by providing me with perspective on different management systems, forms, and procedures. In order to correct systemic and institutional bias and racism in the criminal justice system, judges must be open to changing the status quo. My personal research and exploration of evolving research and innovations in criminal justice has broadened my view of ways to reform our courts to support rehabilitation and diversion programs, while protecting the community from more violent offenders.

24. List any honors, prizes, awards, or other forms of recognition that you have received, whether professional or civic.

Professional -- FBI Prosecution Recognition Award, January, 2002 (recognizing my role in prosecution of bank robberies involving FBI personnel in State Court proceedings).

Civic -- Little League International Softball Volunteer of the Year, 2017

25. Give names, addresses, and telephone numbers of five attorneys or judges who know you best, including at least two attorneys who have opposed you in cases. The Mayor is not seeking letters of recommendation at this time.

Because I have not practiced law as an advocate since 2009, and because I have not personally handled a trial as an advocate since 2001, it is difficult for me to identify attorneys who were opposing counsel in these cases. During my appellate work, Nancy Collins, Washington Appellate Project, 1511 3rd Ave Ste 610, Seattle, WA 98101-3647, 877-587-2711 and Eric Broman, Nielsen Koch, 1908 E Madison St., Seattle, WA 98122-2842, 206-623-2373 each opposed me on a number of appellate cases during my service at King County PAO. The following judges know me well and can serve as professional references.

- Judge Adam Eisenberg, [redacted] (Seattle Municipal Court)
- Judge Ed McKenna [redacted] (Seattle Municipal Court Judge, retired)
- Judge Steve Rosen [redacted] (King County Superior Court Judge and former Seattle Municipal Court Judge)
- Judge Anne Harper [redacted] (King County District Court Judge)
- Judge Arthur Chapman, [redacted] (King County District Court Judge)

26. Please provide information on:

A. Employment history (legal or non-legal)

My legal employment history is documented above, as well as my experience in civic and religious volunteer activities.

B. Have you been ordered to pay sanctions to a Court? If your answer is yes, please provide details.

No.

C. Provide the names of five (5) professional references who have known you for at least five years.

- Jim Whisman, [redacted] (KCPAO Appellate Unit Chair)
- Ann Summers, [redacted] (KCPAO colleague)
- Erin Ehlert [redacted] (KCPAO colleague)
- Robert Flennaugh: [redacted] (Criminal Defense Attorney)
- Ed Allen, [redacted] (Criminal Defense Attorney)

D. Provide the names and telephone numbers of at least three and no more than 5 personal references who have known you for at least five years.

- Bill Condon, [redacted] (Executive Vice President and Managing Director at Colliers International, close personal friend)
- Nicholas Ford, [redacted] (Principal, Our Lady of Fatima School)
- Cammy Hendrix, [redacted] (Victim Assistance Unit Supervisor, King County Prosecuting Attorney's Office, neighbor and friend)

E. Either in your own name or any pseudonym, have you written any published or posted article, editorial or opinion piece (paper or electronic), commented on any blog or other story, been quoted in any news article or blog post, or appeared in any content broadcast on the radio or television? If your answer is yes, please list all such items and provide copies if possible.

- **Contributing Essayist,** This I Believe: Life Lessons, Dan Gediman, John Gregory and Mary Jo Gediman, eds., 2011. Selected for audio recording of essay, broadcast on The Bob Edwards Show, KPLU 88.5FM, October 14, 2011. (Copy attached, and text and audio available at: http://thisibelieve.org/essay/45994/)

- **Note**, Minimum Recycled Content Requirements for Virginia: One Solution to the Solid Waste Crisis, 13 Va. Envt'l L. J. 271 (Winter 1994). This note was written while I was a student at University of Virginia School of Law, and was published under my maiden name, Catherine Myers. (Copy attached, as "Binder3.pdf")

CATHERINE MARIE McDOWALL

SUPPLEMENTAL APPLICATION MATERIALS FOR APPOINTMENT TO SEATTLE MUNICIPAL COURT

BAR ASSOCIATION RATINGS/ENDORSEMENTS

Index

King County Bar Association – Well Qualified, *See letter attached.*

Loren Miller Bar Association- Qualified, *Letter forthcoming and see online rating*

https://www.lmba.net/judicial-evaluations

Washington Women Lawyers- Exceptionally Well Qualified, *See letter attached.*

KING COUNTY BAR ASSOCIATION

[redacted]

kcba.org

Catherine McDowell
[redacted]

September 10, 2020

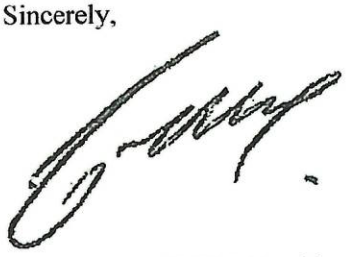
Dear Ms. McDowell:

This letter is to inform you that the King County Bar Association's Judicial Candidate Evaluation Committee has rated you "Well Qualified" for the position of Seattle Municipal Court Judge. This rating is valid for all courts of Limited Jurisdiction in King County.

Your rating will remain in effect for appointment or election until August 20, 2023 three years from the date of your rating which was August 20, 2020. Should you have any questions about your rating, please contact KCBA staff member Anne Daly at AnneD@kcba.org or at [redacted]

The King County Bar Association realizes that our judicial screening process is a demanding one and your participation is greatly appreciated.

Sincerely,



John McKay, KCBA President
2020-2021

Washington Women Lawyers
King County Chapter

Judicial Evaluation Committee

Via Email (catherinemcdowall@gmail.com)

PERSONAL AND CONFIDENTIAL

September 17, 2020

Catherine McDowall
2531 29th Ave. W
Mercer Island, WA 98199

Re: King County Chapter Washington Women Lawyers Judicial Evaluation

Dear Ms. McDowall:

The Judicial Evaluation Committee and the Board have completed their process for evaluation. The King County Chapter of Washington Women Lawyers has confirmed your rating of **Exceptionally Well Qualified** for King County Courts of Limited Jurisdiction. This rating is effective for three (3) years, through September 16, 2023.

We will forward your rating to the appropriate appointing authority if you seek appointment and if you file for election, we post it on votingforjudges.org. We will also post it on our website.

I have scanned and sent this letter via email to save on resources. Please let me know if you would like a hard copy. Thank you for interviewing with our committee.

Very truly yours,

Mary B. Reiten
Judicial Evaluation Committee Co-Chair
Washington Women Lawyers King County chapter

cc: Sarah Perez, KCWWL JEC Co-Chair
KCWWL President
KCWWL Secretary

LETTERS OF SUPPORT

Index

WILLIE GREGORY
PRESIDING JUDGE

September 17, 2020

The Honorable Jenny A. Durkan
Mayor, City of Seattle
600 Fourth Avenue, 7th Floor
Seattle, WA 98104

RE: Letter of Recommendation for Catherine McDowell

Dear Mayor Durkan:

I highly recommend Catherine McDowell to serve as a Judge in Seattle Municipal Court. I believe she will bring a lot to the bench.

Catherine McDowell has been working as a Pro Tem Judge in Seattle Municipal Court for seven years. During that time, she has stood out as a Pro Tem Judge. She has responded on short notice when called by court staff to cover for a judge who is sick or on vacation and handle that judge's calendar with intelligence and respect for the parties. Catherine has gained the respect of the city attorneys and defense attorneys who practice before her. Likewise, she has gained the respect of the judges of Seattle Municipal Court due to her willingness to step in and preside over any type of case.

Catherine will able to come to the Seattle Municipal Court bench with minimal training due to her knowledge of our laws, procedures, and policies. She has shown the willingness to seek advice if an issue comes up that is novel to her.

The Seattle Municipal Court has taken upon itself to put into effect numerous court reforms. Catherine is knowledgeable about these reforms and she is willing to engage in these reforms with the bench. She is a collaborator and with the current court she will be an innovator helping to advance the court's reforms

I am looking forward to working with her as a judge in Seattle Municipal Court.

Sincerely,
Willie J. Gregory
Willie Gregory, Presiding Judge
Seattle Municipal Court

THE MUNICIPAL COURT OF SEATTLE
Adam Eisenberg
Judge

September 16, 2020

The Honorable Jenny A. Durkan
Mayor, City of Seattle
600 Fourth Avenue, 7th Floor
Seattle, WA 98104

RE: Letter of Reference for Catherine McDowall for Seattle Municipal Court

Dear Mayor Durkan:

It is my great pleasure to write this letter in support of Pro Tem Judge Catherine McDowall for an appointment to the Seattle Municipal Court bench.

I have known Pro Tem Judge McDowall since 2013 when she first started serving as a pro tem judge for SMC. Since then, she has proven time and again that she is an excellent jurist. She has handled every type of calendar, from jail arraignments and pretrial hearings to jury trials and reviews. She does so with great skill and empathy, and has earned the respect of defense attorneys, prosecutors, and our court staff. In addition, she has extensive experience as a pro tem for King County Superior and District Courts.

Our bench has so much confidence in Pro Tem Judge McDowall that she has been preassigned legally complex and high profiles cases. For instance, in 2014 she presided over a three-week trial involving several Seattle firefighters who had been charged with assault. She has also issued written opinions in cases involving challenging legal issues, including a well-reasoned 20 page decision regarding First Amendment implications of a 2018 multiple-defendant protest case.

Over the past seven years, Pro Tem Judge McDowall and I have often discussed cases we're handling and challenging legal issues that come up. I always find her counsel to be insightful, and she constantly impresses me with her keen knowledge of the law, her compassion, and her strong sense of justice.

Pro Tem Judge McDowall is, simply put, an extraordinary person and excellent jurist, and she comes to you with my highest recommendation.

Yours sincerely,

Adam Eisenberg
Judge, Seattle Municipal Court

Seattle Justice Center, 600 Fifth Ave. Room 1037, P.O. Box 34987, Seattle, WA 98124-4987
Tel: (206) 684-8709 Fax: (206) 615-0766

THE MUNICIPAL COURT OF SEATTLE

Faye R. Chess
Judge

The Honorable Mayor Jenny Durkan
Office of the Mayor
P.O. Box 94749
Seattle, WA 98124-4749

Via Email: Michelle.Chen@seattle.gov

Dear Mayor Durkan:

It is my pleasure to recommend Catherine McDowall for the open judicial position in Seattle Municipal Court (SMC).

Catherine has served as a SMC Pro Tem Judge and Magistrate since 2016. She has routinely presided on matters ranging from arraignments, pre-trial hearings, trials, sentencing hearings, review hearings, and traffic infractions hearings.

Catherine is well versed on Washington State laws. She generates well-developed and comprehensive rulings. She is well respected in this courthouse. I know her to be of high intelligence and good character. She approaches her work at SMC with due diligence, taking pride in her work, and possessing excellent work ethics. She has demonstrated that she can work collaboratively with the court's staff, Magistrates, and Judges. It is rare and ever has an affidavit been filed against her by either the city assistant attorneys, public defenders, or defense bar.

Based on her experience as a long-term Pro Tem Judge in SMC, King County District Court, and King County Superior Court, Catherine will be an invaluable asset to our bench. In the times of COVID and limited in-person staffing, she will be able to assume the position with little to no training necessary.

I regard Catherine as a legal professional who is committed to the rule of law and dedicated to making sure that the courts of law are considered an independent and coequal branch of government which is accessible to the public and provides fair and impartial justice.

I have no doubt Catherine will be an invaluable asset to SMC, a community court.

Sincerely,

Judge Faye R. Chess

Seattle Justice Center, Room 1037, 600 Fifth Ave., P.O. Box 34987, Seattle, WA 98124-4987
Tel: (206) 684-8709 Fax: (206) 615-0766

September 17, 2020

The Honorable Mayor Jenny Durkan
Office of the Mayor
PO Box 94749
Seattle, WA 98124-4749

RE: Letter of Recommendation for Catherine McDowall

Mayor Durkan,

I am grateful for the opportunity to write this letter on behalf of Catherine McDowall for Seattle Municipal Court Judge. I have been the King County District Court Seattle Manager since 2013 and had the pleasure of meeting Ms. McDowall in 2016.

The first time that I met Ms. McDowall was when she came to King County District Court to be sworn in by one of our Judges. We spoke at length about her working experience as a Pro Tem Judge in Seattle Municipal Court. I found her to be a professional and amiable person with a depth of knowledge and experience with both civil and criminal calendars. She also had a clear desire to work with our court.

Her demeanor with me, my staff, our sitting Judges, and all parties to a case has been exemplary in that she has always treated everyone in an equitable manner and with the utmost respect. I have worked with many Pro Tem Judges over the years, and she has continuously been asked to return. It is vital to any court to maintain its impartiality. Ms. McDowall has maintained her commitment to taking into consideration all those aspects of a case, from a victim's account of an incident to a defendant's financial resources, when executing any type of order.

When Ms. McDowall informed me that she was pursuing this position, I was both excited and sad. I was excited because I believe that she would be an asset to the criminal justice system within King County as a sitting Judge and extremely sad because I would no longer be able to ask her to represent King County District Court on the bench. From my experience working with her as a Pro Tem Judge over the past 4 years, she has shown me her dedication and commitment to serving our community. I hold Ms. McDowall in the highest of regards and am confident that she would perform her duties as a Seattle Municipal Court Judge with the utmost of competence and enthusiasm.

Sincerely,

Lori A Holtzapple

Lori A Holtzapple
King County District Court – Court Manager
516 3rd Ave, Room E327
Seattle, WA 98104
Phone: 206-477-6975

September 16, 2020

The Honorable Mayor Jenny Durkan
c/o Michelle Chen
Office of the Mayor
P.O. Box 94749
Seattle, Washington 98124-4749

Re: Letter of Recommendation for Catherine McDowall

Dear Mayor Durkan:

It is my pleasure to recommend Catherine McDowall for Seattle Municipal Court judge.

I have been chair of the appellate unit in the King County Prosecutor's Office since 1997. Ms. McDowall served as a deputy prosecutor on the appellate unit in the year 2000 and again from 2003 until 2009. She worked on a number of very challenging cases during that time and I was always impressed by her intelligence and efficiency in sorting through complex legal issues. Ms. McDowall is a very talented lawyer and a gifted writer.

Ms. McDowall is also highly principled and always considered the effects of her decisions on defendants and on the community. I could always depend on her to think independently and to ask tough, critical questions of her own work and the work of others on the unit. Her willingness to think outside the box and to speak up for what is right – even as a young lawyer and even when her input met with resistance – was much appreciated.

Ms. McDowall is also an excellent colleague. She collaborated very well with her peers, with people she supervised, and with staff. She was always entirely professional, approachable, and eager to learn, and as a senior deputy, eager to teach others. I am certain that she has retained these traits and that her basic human decency would shine through in her service to the people of Seattle. I am confident that her record as a pro tempore judge in both Seattle Municipal Court and the King County District Courts would bear this out.

Please feel free to call if you have any questions about Ms. McDowall's experience or qualifications to be a Seattle Municipal Court judge.

Sincerely,

James M. Whisman
Senior Deputy Prosecuting Attorney
Appellate Unit Chair
King County Prosecutor's Office
206-477-9577

RESUME/COVER LETTER

Catherine McDowall

[redacted]

WSBA #27737

September 9, 2020

Michelle Chen
City of Seattle Mayor's Office
600 4th Avenue, 7th Floor
Seattle, WA 98104

Ms. Chen,

I am writing to request consideration for appointment to the judicial vacancy on Seattle Municipal Court. I have previously submitted materials in support of this application via email. Since submitting those materials, I have received a rating of "Well Qualified" from the King County Bar Association. I have evaluation applications pending with the King County chapter of Washington Women Lawyers and the Loren Miller Bar Association this week and will forward information on their ratings when I receive them.

From 1998 through 2009, I served King County as a Deputy Prosecuting Attorney. My seven years of experience in the appellate division of that office reinforced for me the importance of fair, well-reasoned legal decisions and accurately completed forms. I also gained a broad understanding of Washington law as it is applied in the criminal courts of this State. After the birth of my fourth child in 2009, I resigned from the Prosecutor's office to focus on my family and my local community.

For the past seven years, I have been serving as a Pro Tem Judge in Seattle Municipal Court and in King County District Court. I have become well-acquainted with the procedures and personnel at the Court, and I have served in each of the specialty courts including Mental Health Court, Community Court, and Veteran's Court. In addition, I often served in the jail on the first appearance and warrant calendars. During this time, I have demonstrated an ability to handle the high volume of cases in municipal court efficiently and fairly. I consider myself a lifelong learner and pride myself on my ability to seek competing opinions and information on any given issue, and to receive information with an open mind to render a fair decision that comports with applicable law.

Based on this experience, I am confident that I am a good fit for this judicial vacancy. I have enclosed a current resume for your review. Please let me know if I can provide any additional materials or information to aid your decision. Thank you for your consideration.

Sincerely,

Catherine M. McDowall

Catherine McDowall

[redacted]

WSBA #27737

EXPERIENCE

JUDGE PRO TEMPORE

- ***King County Superior Court, Juvenile Division.*** 2015-present.
- ***King County District Court, Seattle and Shoreline Divisions***. 2016-present.
- ***Seattle Municipal Court.*** 2013-present.
  Preside over civil, criminal, and infraction hearings.

KING COUNTY PROSECUTING ATTORNEY OFFICE

- ***Senior Deputy Prosecuting Attorney, 2005-2009.***
- ***Deputy Prosecuting Attorney, 1998-2005.***
  - Served King County by prosecuting misdemeanor and felony crimes at all levels of Washington's court system and at all levels of prosecution from filing through appeals.
  - From 2002-2009, served in Appellate Unit prosecuting appeals at all levels of Washington State court system, including two cases before the State Supreme Court.
  - Conducted in-house CLE trainings on a variety of topics related to criminal law.

SONNENSCHEIN, NATH & ROSENTHAL (Now, Dentons), Washington, D.C.
Litigation Associate, 1995-1997. Practiced civil litigation in state and federal courts.

EDUCATION

University of Virginia School of Law, Charlottesville, VA. *J.D., May, 1995.*
Northwestern University, Evanston, IL. *B.A., May, 1991.*

COMMUNITY INVOLVEMENT

Our Lady of Fatima Parish and School, Seattle, WA

- ***Member, Parish Council, 2018-present.*** Advise pastor on parish matters.
- ***Member, School Commission, 2016-2018.*** Advise principal on school budget and other issues.
- ***Magnolia Moms, Member, 2002-2016.*** Assist in activities of local charitable organization whose mission is to help women's and children's charities in King County.
- ***Religious Education Catechist, 2001-2013.*** Taught religion to first grade students in parish.

Magnolia Little League, Seattle, WA

- Board member, 2013-present.
- Vice President, Softball Division, 2013-2017.
- Assistant coach for tee ball and softball, 2012-2014.
- Little League International Softball Volunteer of the Year, 2017.

PUBLICATIONS

Contributing Essayist, This I Believe: Life Lessons, Dan Gediman, John Gregory and Mary Jo Gediman, eds., 2011. Selected for audio recording of essay, broadcast on *The Bob Edwards Show,* KPLU 88.5FM, October 14, 2011. *http://thisibelieve.org/essay/45994/*

Note, *Minimum Recycled Content Requirements for Virginia: One Solution to the Solid Waste Crisis,* 13 Va. Envt'l L. J. 271 (Winter 1994).

WRITING SAMPLE

IN THE MUNICIPAL COURT OF THE CITY OF SEATTLE
KING COUNTY, WASHINGTON

City of Seattle,

Plaintiff,

vs.

Robert Allen BARNES, Helena BENEDICT, Aaron S. BROUILETTE, Kaelyn Marie CALDWELL, Sean Patrick CARNEY, Victoria Jo DeMARCO, Eva R. DOUGHERTY, Max R. FRIEDFELD, Sean Kenji FUJIMORI, Erin Marie GARCIA, Anthony Lynn HADDEN, Ross G. KIRSHENBAUM, Daniel LANGE, Barbara Jean LEWY, Cynthia LINET, Sareni RUIZ, Alan K. SATO, Jason Lee SCHROEDER, Noel Randall SHERRARD, Megan A. YBARRA, and Antonio S. ZAMORA

Defendants;

Case No. 638607, 636226, 637640, 636225, 637310, 635421, 635420, 635423, 637309, 634875, 634877, 635424, 637308, 634882, 634876, 635419, 637305, 634880, 637668, 636277, and 637307

ORDER ON CONSOLIDATED MOTIONS TO DISMISS AND FOR OTHER RELIEF

I. Introduction

A. Factual Background

The cases before this court for these motions arose from two separate demonstrations held in downtown Seattle. The City of Seattle charged twelve defendants as a result of arrests made during a May 7, 2018 demonstration in the 1300 block of Second Avenue, near a Chase bank branch. Four of these defendants (Brouillette, Lange, Fujimori, and Zamora) were

charged with pedestrian interference and obstruction for failing to heed police direction to come down from temporary structures ("tarpees") erected by the group in the street. Seven defendants (Carney, Garcia, Hadden, Lewy, Linet, Schroeder, and Sato) were charged with pedestrian interference for obstructing traffic on Second Avenue by standing in the roadway with linked arms, and for failing to disperse when ordered by police. Defendant Barnes was charged (on a complicity theory) with pedestrian interference and obstruction[1] for his role in coordinating the demonstration.

The City of Seattle charged nine other defendants (Benedict, Caldwell, DeMarco, Dougherty, Friedfeld, Kirshenbaum, Ruiz, Sherrard, and Ybarra) with pedestrian interference and obstruction resulting from arrests made during a demonstration on June 5, 2018. This demonstration also took place on Second Avenue in the downtown corridor. These defendants blocked all lanes of traffic by linking arms in a "sleeping dragon" apparatus that included PVC piping treated with a number of materials and substances designed to frustrate police attempts to disperse the group.

B. Procedural History

In late September or early October, the Seattle City Attorney filed charges against each of these defendants for their involvement in the above-described protests. At or after pretrial hearings, the parties filed the following substantive motions:

- BARNES filed a "MOTION FOR DISMISSAL, SANCTIONS OR DISCOVERY" on December 27, 2018. (hereinafter, "Barnes Motion to Dismiss")
- BARNES filed a "MOTION TO DISMISS OBSTRUCTING COUNT BASED ON *APPRENDI*" on December 27, 2018 (hereinafter "*Apprendi* Motion")

[1] At the motions hearing on March 1, 2019, the City moved to dismiss the Obstruction charge and that motion was granted by this court.

- FUJIMORI filed a "*KNAPSTAD* MOTION TO DISMISS FOR FACTS INSUFFICIENT TO SUPPORT PROSECUTION" on February 2, 2019 (hereinafter, "Fujimori *Knapstad* Motions"
- LANGE filed "MOTIONS TO JOIN CO-DEFENDANTS MOTIONS AND *DE MINIMIS* MOTION TO DISMISS" on February 12, 2019 (hereinafter, "*De Minimis* Motion"
- LINET filed "MOTIONS TO JOIN CO-DEFENDANT MOTIONS AND FOR DISMISSAL AND DISCOVERY" on February 8, 2019 (hereinafter "Linet Motion to Dismiss")
- BARNES also filed a *Knapstad* Motion specific to the facts of his case, on February 18, 2019 (hereinafter "Barnes *Knapstad* Motion")

Prior to or at oral argument for these motions, each of the defendants moved to join in the motions made by the other defendants. The cases were consolidated for consideration of these joint motions. The cases have not been joined for trial or any other purpose.

In the following ruling, the court will address each motion as noted above. To the extent that any defendant has joined in those motions, the ruling applies with equal force to each of those defendants, whether specifically named or not.

II. Barnes Motion to Dismiss

Defendants have raised a number of overlapping issues in these consolidated motions. Many of the legal theories raised in the motions to dismiss rest on the premise that the prosecutions are unjust because the defendants were merely exercising their constitutional right to free speech. Therefore, this court will first address the Barnes Motion to Dismiss. The primary theories of Barnes's motion is that the First Amendment protects the defendants from "non-violent" protests, and that the "unfettered discretion" exercised by the police violated the rights of the defendants.

It is unquestioned that the purpose of each of the demonstrations was to raise awareness of various political causes. Thus, the defendants were clearly engaging in protected speech, at

least at the outset of their demonstrations. The arrests, therefore, resulted from police actions that placed a time, manner, and place restriction on the exercise of this right. The central question in these cases is whether the police actions place *unconstitutional* restrictions on the time, manner, and place of the defendants' speech.

This analysis has three inquiries. One, was the action of the police content neutral? Two, was the police action narrowly tailored to serve a significant government interest? And three, did the police actions leave ample alternative channels of communication? *Menotti v. City of Seattle*, 409 F.3d 1113, 1128 (9th Cir. 2005).

First, the police action in this case resulted from policies that were clearly content neutral. Neither the pedestrian interference ordinance nor the obstruction ordinance seek to regulate speech at all, much less speech containing any particular message. SMC 12A.12.015; SMC 12A.16.010. Rather, each of these ordinances regulates *conduct*. Therefore, the question becomes whether the *police action* was content neutral. In each of these cases, the stated reasons for arresting the defendants had nothing at all to do with the content of the speech. Rather, the arrests resulted from a police determination that the disruption to city traffic was substantial, and that the demonstrators' and spectators' safety may be at risk. These decisions had nothing at all to do with the content of the message conveyed by either group of demonstrators. Therefore, the police actions were content neutral.[2]

Second, the police action was narrowly tailored to serve a significant government interest. "No one could seriously dispute that the government has a significant interest in

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[2] Notably, the police report for the June demonstrations does not even mention the purpose of the demonstration. The only reference to the content or purpose of the demonstration is contained in the parties briefs on these motions, and possibly the body-cam video that might depict signs or other indications of the purpose of the demonstration.

maintaining public order." *Menotti*, 409 F.3d at 1131. City governments in particular have a significant interest in maintaining the flow of traffic within city limits. As the U.S. Supreme Court has observed, "the exercise of First Amendment rights may be regulated where such exercise will unduly interfere with the normal use of the public property by other members of the public with an equal right of access to it." *Food Employees v. Logan Valley Plaza*, 391 U.S. 308, 320-321 (1968). Moreover, when the exercise of free speech involves conduct unrelated to the content of the message, governments undoubtedly may act to restrain the conduct that interferes with public safety or order. As one commentator has noted:

> Blocking highways does not constitute legally protected speech. Disrupting traffic is dangerous, and can be fatal, both to the protesters and to the public, especially if emergency responders cannot traverse public roads. Police may legally arrest or disperse these activists, who are engaging in civil disobedience.[3]

In both the May and June protests, police personnel were following standard guidelines that permit officers to move to disperse demonstrations when there is a substantial obstruction of traffic.[4] These policies were clearly drafted and adopted to further the goal of permitting reasonable First Amendment expression, balanced against the goal of maintaining public order. In the cases before this court, police permitted the disruption of traffic for a substantial period of time (several hours, in the case of the May protests) before attempting to clear the streets of the intentional blockage by the demonstrators.

Third, the police actions in this case allowed for ample alternative channels of communication. The police first tried to move the participants out of the street and onto the

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[3] Erica Goldberg, Competing Free Speech Values in an Age of Protest, 39 Cardoza Law Review, 2163, 2206 (Aug. 2018).

[4] See Barnes Supplemental Materials, Exs. 5 and 6.

sidewalks. The only people arrested were those who refused to abide by police orders to leave the roadway. There is no evidence that the police attempted to prevent protestors from continuing their demonstration from the sidewalks. It is clear that the main purpose of the police actions in this case was to clear the roadway to allow traffic to progress down this busy, main thoroughfare.

The First Amendment only requires that the government refrain from denying "reasonable opportunities" for communication. In this case, the police did not attempt to silence the demonstrators in any way; rather, they simply tried to get the defendants to stop obstructing traffic. Thus, the actions of police and city government here were aimed squarely at behavior and actions, not at expressive speech.

In short, the time, place and manner restrictions placed on the demonstrators in these cases were entirely reasonable. Police allowed the protests to continue for several hours, and only when the disruption to pedestrian and vehicle traffic became extreme did the the police attempt to move the demonstrations off the roadway. In the June demonstration, there is even evidence that citizens affected by the blockage were becoming angry and threatening.[5] The police actions were designed to protect the protesters as much as to allow traffic to progress.

The defendants have argued that the guidelines and policies adopted by the police give too much discretion to the officers on the scene. Many of the cases they have cited in support of this argument, however, all involve permitting decisions or policies. *Battle v. City of Seattle*, 89 F. Supp. 3d 1092 (W.D. Wash. 2015) (challenging Street Use Ordinance); *Seattle Affiliate v. City of Seattle*, 550 F.3d 788 (2008) (challenging authority of police chief to issue, deny or

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[5] See, e.g., SPD GO 2018-202829 at page 15 of 181 (911 caller complaining about the protest told dispatcher "I'll go down there and take care of this myself!" and hung up on the dispatcher).

modify parade permits). These challenges, therefore, involve prior restraints by government on speech activities and are subject to a different legal analysis. Furthermore, the demonstrations in the cases before this court were both unpermitted demonstrations for which police had little or no notice to prepare.

Police procedures (whether reduced to writing as in the "Rules of Engagement" or unofficially "announced" in public statements by police officials) cannot, and should not, be evaluated under a prior restraint analysis. These policies are designed to govern a wide range of situations and behavior, in order to allow police to evaluate individual safety concerns, disruption of traffic, and use of resources. Police officers necessarily exercise their discretion on how best to ensure community safety every day. Unless that discretion is used in a conclusively arbitrary or discriminatory way, the police action does not violate the First Amendment. See *People v. Galpern*, 181 N.E. 572 (N.Y. 1932) ("The courts cannot weigh opposing consideration as to the wisdom of the police officer's directions when a police officer is called upon to decide whether the time has come in which some directions are called for.")

Moreover, the procedures and policies announce a number of considerations police will use when deciding whether to disperse a street or traffic disruption. These content neutral considerations (whether the disruption to traffic is substantial, whether other critical services must be diverted to handle the protest, whether persons or property are endangered) are reasonable guidelines for police to follow when evaluating whether and when to put a stop to disruptive protests like the ones at issue here. Police made efforts to allow the protests to continue for a significant period of time. Once the police began warning protesters to leave the streets and it became clear that the protesters would not obey police commands to clear the

area, it was entirely proper for police to arrest the defendants for violating pedestrian interference and obstruction ordinances.

> [T]he law is clear that while speech may be protected, Plaintiff's choice to disobey police orders is not...A refusal to obey such an order can be justified only where the circumstances show conclusively that the police officer's direction was purely arbitrary and was not calculated in any way to promote the public order.

Mediavilla v. City of New York, 259 F. Supp. 3d 82, 99 (S.D.N.Y. 2016).

Because the police action in these cases were plainly and conclusively related to maintaining (or restoring) public order by clearing streets to permit the flow of traffic to resume, there can be no question that these were not arbitrary actions. Once the police ordered the defendants to disperse, and the defendants disobeyed those police orders, the defendants were not lawfully exercising their rights to freedom of speech or assembly.

Based on this analysis, the court denies Barnes Motion to Dismiss.[6]

Defendant Barnes has not offered any evidence that the discovery he seeks related to police policies on how to handle public demonstrations would affect the analysis above in any way. Therefore, Barnes Motions for Discovery or Sanctions are also denied.

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[6] Defendant Barnes also relies on international law, which he argues provide "parallel protections" to the U.S. Constitution's First Amendment. Barnes cites no authority that indicates that international law provides any protection that is greater than that provided by the U.S. Constitution. Absent such authority, this court denies Barnes's Motion to Dismiss on this ground as well.

III. *Knapstad Motion*

A. Fujimori *Knapstad* Motions

1. Pedestrian Interference Charges

A trial court may dismiss a prosecution prior to trial, "if the State's pleadings . . . are insufficient to raise a jury issue on all elements of the charge." State v. Knapstad, 107 Wn.2d 346, 352, 729 P.2d 48 (1986). Fujimori argues that the pedestrian interference and obstruction charges as to each defendant must be dismissed because the City cannot prove that he violated the ordinances as a matter of law.

The pedestrian interference ordinance provides:

> B. A person is guilty of pedestrian interference if, in a public place, he or she intentionally:
>
> 1. Obstructs pedestrian or vehicular traffic; or
> 2. Aggressively begs.

SMC 12A.12.015. The ordinance defines "obstructs pedestrian or vehicular traffic," but specifically exempts "Acts authorized as an exercise of one's constitutional right to picket or to legally protest." SMC 12A.12.015(A)(4).

Fujimori contends that because his actions constitute an exercise of his constitutional rights to free speech, the City cannot prove that he obstructed pedestrian or vehicular traffic, as defined by the statute, beyond a reasonable doubt. The question of whether the defendants were exercising "authorized" constitutional rights or whether they were "legally protest[ing]" is a question of law to be determined by the court. However, as explained in the preceding section, once the defendants failed to heed the officer's directions to clear the street, the defendants' conduct failed to be protected by the First Amendment. Thus, his *Knapstad* argument fails.

At oral argument, defense counsel asserted that the City would not be able to prove that the defendants "knew" that they were not acting outside the scope of their First Amendment rights when they refused the police orders. This argument fails because under Washington law, a defendant may still be liable if he intends to do an act, even if he is under the mistaken impression that the act does not constitute a crime. RCW 9A.08.010; See also, WPIC 10.01, WPIC 10.02. The defendants' subjective beliefs that that were acting lawfully are irrelevant to these charges, and irrelevant to the *Knapstad* analysis.

2. Obstruction Charges

Similarly, the obstruction ordinance under which these defendants were charged criminalized "intentionally refus[ing] to cease an activity or behavior that creates a risk of injury to any person when ordered to do so by a public officer." SMC 12A.16.010(A)(3). This ordinance also carves out an exception to conviction, by providing that "No person shall be convicted of violating this section if the Judge determines, with respect to the person charged with violating this section, that the public officer was not acting lawfully in a governmental function." SMC 12A.16.010(B). Thus, if the police were violating defendants' First Amendment rights, the police acted "unlawfully" and this would be a defense to the charge.

However, as noted in the previous section, the police acted lawfully when they began to try to clear the streets of the protest. Therefore, the *Knapstad* motion with respect to the obstruction charges also fails.

B. Barnes's *Knapstad* Motion to Dismiss

Defendant Barnes raises a *Knapstad* motion that only applies to his unique facts. Barnes is described in the police reports as the "organizer" of the May protests, and he served as the main contact between the police and the protesters as the situation

progressed. The judge at arraignment was not presented with the complicity theory that is now offered by the City to explain the basis of its charges.

Based upon the information contained in the police reports, there is a factual issue as to the extent of Barnes's involvement in the continued conduct of blocking traffic during the duration of the protest. The court denies the motion to dismiss on this basis, without prejudice to Barnes to renew this motion after the City's evidence is produced at trial.

IV. *Apprendi* Motion

Defendants[7] challenge Seattle's obstruction ordinance as unconstitutional because it violates his Sixth Amendment right to a jury determination of each element of the crime. His claim rests upon the contention that SMC 12A.16.010(B) unconstitutionally removes from jury consideration the question of whether the officer was acting "lawfully" in his actions.

This issue was addressed directly in *City of Seattle v. Lewis*, 70 Wn. App. 715 (Div. 1 1993). In that case, the appellate court upheld the obstruction ordinance based on a similar challenge:

> Here, we find the question of whether the public officer was acting legally remains where the Seattle City Council put it -- as a defense that must be raised by the defendant and ruled upon by the judge.

Lewis, 70 Wn. App. at 718. This court finds that *Lewis* controls this issue.

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[7] Barnes's obstruction charge was dismissed on the City's motion at oral argument. Because the other defendants joined in Barnes motion, the court will still address the legal theory argued by Barnes with respect to the obstruction charges.

Defendants argue that subsequent U.S. Supreme Court decisions effectively overrule *Lewis.*[8] They are incorrect. In *Apprendi*, *Ring*, *Blakely*, and *Hurst*, a sentencing scheme allowed a judge to make a factual finding that *increased the maximum sentence* for the crime with which the defendant was charged. Similarly, the *Gaudin* Court held that a determination of whether a fact was "material" must be decided by a jury because it was an element of the offense charged. *Gaudin* 515 U.S. at 509. Thus, the determination of materiality was a necessary element to proving the defendant's liability.

In contrast, the provision of the obstruction ordinance here does not increase any penalty to the defendant or enhance the obstruction count in any way. In fact, a judicial determination that the officers were acting unlawfully completely *relieves* the defendant of liability, the exact opposite of the situation present in the *Apprendi* cases. A jury must find that the defendant's conduct satisfied all the elements of the obstruction charge, namely, that the defendant "intentionally refus[ed] to cease an activity or behavior that creates a risk of injury to any person when ordered to do so by a public officer." SMC 12A.16.010(A)(3). If the officer's actions were unlawful, a judge may dismiss a charge. This does not increase any punishment for the offense, it can only negate the charge altogether.

More significantly, the determination of whether an officer's conduct was lawful is a legal determination properly made by the trial judge. Many post-*Apprendi* cases in Washington support this conclusion. For example, in *State v. Wu*, 431 P.3d 1070 (Div. 1 2018), the appellate court held that the "fact" of a prior DUI conviction is an issue for the jury, but the

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[8] *Apprendi* Motion, at 4-6 (citing *United States v. Gaudin*, 515 U.S. 506 (1995); *Apprendi v. New Jersey*, 530 U.S. 466 (2000); *Ring v. Arizona*, 536 U.S. 584 (2002); Blakely v. Washington, 542 U.S. .296 (2004) and *Hurst v. Florida*, 577 U.S. ___ , 136 S.Ct. 616, 193 L.E.2d 504 (2016).

"validity" of that conviction is a threshold matter to be determined by the trial court. 431 P.3d at 1073. Similarly, in *State v. Gray*, 134 Wn. App. 547, 138 P.3d 1123 (Div. 1 2006), the court held that the fact of a prior convictions for violating a no contact order was properly decided by a jury in a case where defendant was charged with felony violation of a no contact order. However, that court held that the question of the validity of the orders was a threshold question of law to be decided by the trial court. In *Gray*, the court explicitly rejected the defendant's contention that *Apprendi* or *Blakely* affected the ability of the court to determine these questions of law. *Gray*, 138 P.3d at 1127-28.

Seattle's obstruction ordinance requires a jury to find the *fact* that the defendant refused to cease an activity "when ordered to do so by a public officer." SMC 12A.16.010(A)(3). This satisfies the Sixth Amendment right to a jury determination on every element of the offense. The question of whether a public officer was acting "lawfully" when giving that order is a legal question that is properly decided by a judge. Lewis, 70 Wn. App. at 718-19. *Apprendi* and later cases do not change this analysis or conclusion.

V. ***De Minimis* Motion**

Defendant Lange moves this court to dismiss the pedestrian interference charges on the basis of SMC 12A.04.180 (De minimis infractions). This ordinance allows, but does not require, a trial court to dismiss a prosecution if it finds that the defendant's conduct:

A. Was within a customary license or tolerance not inconsistent with the purpose of the law defining the offense; or

B. Did not actually cause or threaten the harm or evil sought to be prevented by the law defining the offense or did so only to an extent too trivial to warrant condemnation of conviction

SMC 12A.04.180. The decision to dismiss a prosecution on this basis is completely discretionary, in that the ordinance explicitly states that a trial court "may" dismiss a prosecution under one of the situations described in the sections that follow.

Lange's primary argument is that because the defendants' actions in these cases began from an exercise of First Amendment rights of free speech and assembly, and because the ordinance explicitly exempts acts "authorized as an exercise of one's constitutional right to picket or legally protest," this court should find that the defendants' actions were within the customary license or tolerance of the ordinance.

The court rejects this argument. The clear purpose of the pedestrian interference statute is to *prevent obstruction of pedestrian and vehicular traffic*. As noted above, the defendants in these cases were not engaging in protected First Amendment conduct when they refused lawful orders of the police to disperse and refused to remove themselves (and their structures) from the roadway.

Moreover, there was nothing "trivial" about the disruptions caused by the defendants' behavior. Both of these demonstrations had a substantial effect on traffic -- not just on the streets were the protests occurred, but also many surrounding streets and throughout the downtown core. The defendants' actions had a substantial impact on the rights of citizens attempting to use the public roadways to travel throughout the city. The defendants' actions required substantial resources to be deployed to maintain order, including specialized units to remove demonstrators from the tops of the tarpees and to disengage the defendants from the sleeping dragon apparatus.

The fact that <u>one purpose</u> of the Pedestrian Interference ordinance was to target "aggressive panhandling" in the city does not mean that the ordinance was not also designed to

protect public thoroughfares and sidewalks from obstructive behavior. See *De Minimis* Motion at 6-7 (citing legislative history of the ordinance and "contemporaneous media coverage."). The preamble of the ordinance mentions not only panhandling but the desire to provide "all citizens … [with] free and unhampered access to public areas." This preamble, together with the extraordinarily clear prohibition on obstructing public roadways contained in the ordinance itself, demonstrate the City Council's intent to prohibit exactly the kind of actions these defendants took to obstruct the flow of traffic. This is not an appropriate instance to use the court's discretion to dismiss prosecutions as permitted by the *de minimis* ordinance.

VI. Linet's Motion to Dismiss

A. Prosecutorial vindictiveness.

Defendant Linet first asks this court to dismiss these prosecutions on the basis of prosecutorial vindictiveness. "Prosecutorial vindictiveness occurs when the government acts against a defendant in response to the defendant's prior exercise of constitutional or statutory rights." *State v. Korum*, 157 Wn.2d 614 (2006) (internal quotations omitted). Linet argues that the prosecutor's charging decisions in these cases were pressed "without evidence sufficient to convict" or based on "unjustifiable standards", (citing *State v. Penn*, 32 Wn. App. 911 (1982)) or that the charging decisions constituted "arbitrary action" that should be dismissed under CrR 8.3(b). (citing *State v. Bible*, 77 Wn. App. 470 (1995)).

The thrust of Linet's claim of vindictiveness relies on the premise that the defendants were merely exercising their constitutional rights to freedom of speech and assembly, and therefore the filing of charges was retaliation for the exercise of this right. But as noted in the previous sections, the defendants' actions exceeded the scope of their First Amendment rights,

and they were not acting lawfully when they failed to heed officers' warnings to clear the streets.

Moreover, the very evidence that Linet (and other defendants) cite in support of the vindictiveness claim -- the Op-Ed submitted by the City Attorney to the Seattle Times -- belies their claim of vindictiveness. The Op-Ed explains in detail why the City Attorney filed charges in these cases. His stated reasons for filing charges in these cases (i.e., because the demonstrations "unlawfully interfere[d] with other people's lives and compel[led] the redirection of life-safety resources") demonstrates that he is not filing charges on the basis of the content of any particular message or protest. Rather, the City Attorney lays out the content-neutral basis for his filing standards and gives notice as to how he will choose to exercise his broad prosecutorial discretion. Korum, 157 Wn.2d at 625 (prosecutors have broad discretion to determine when and whether to file criminal charges). The filing of these charges does not support a claim of "vindictivness" on this basis.

B. CrR 8.3 Motion to Dismiss

Linet also argues that CrR 8.3(b) requires dismissal in this case because the City Attorney violated the Rules of Professional Conduct by making extrajudicial statements regarding his filing decision in the Op-Ed he submitted to the Seattle Times. This claim alleges that Holmes made "false statements of material fact to third parties," (RPC 4.1), making extrajudicial comments that are likely to materially prejudice an adjudicative proceeding (RPC 3.6), and making extrajudicial statements that "have a substantial likelihood of heightening public condemnation of the accused." (RPC 3.8(f)).

Linet has failed to demonstrate that any of the information contained in Holmes's opinion essay contained false statements of "material" facts. For example, Linet's brief

contests the City Attorney's characterization of street blocking protests or use of sleeping dragon type apparatus as "new" is a material falsehood. To a certain degree, Linet's criticism of this characterization is well-taken. Protesters have historically blocked streets for short periods of time with non-violent protests, for example, in the 1960s civil rights protests, the WTO and Occupy Seattle protests in the City of Seattle, and of course, the annual May Day protests. However, the "newness" of this type of protest is not *material* to the issues presented in the cases at bar.

Nor does Linet demonstrate that Holmes violated RPC 3.6 and 3.8(f). RPC 3.6 explicitly allows attorneys to make statements regarding a number of neutral issues, including any information contained in the public record, and the scheduling of any step in the litigation. RPC 3.8(f) also explicitly exempts

> statements that are necessary to inform the public of the nature and extent of the prosecutor's action and that serve a legitimate law enforcement purpose[.]

RPC 3.8(f). Linet contends that the Op-Ed essay violates this rule because it was not "necessary" for the City Attorney to inform the public of the reasons for his filing decisions, and because it was likely to "poison the well" of prospective jurors.

These claims are also without merit. The extent of media coverage of these types of protests in general, and of these specific protests in particular, depicts a growing public outrage over public inconvenience caused by these demonstrations. The fact that four[9] of these traffic-blocking protests occurred over a relatively short period of time, each receiving media coverage, illustrates at least a perceived increase in these types of protests. This reaction

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[9] The materials submitted by the parties reference at least four protests between March 2, 2018 and June 5, 2018: March 2 (youth jail protest), May 1 (May Day protests), May 7 (tarpee incident), and June 5 (anti-ICE protest).

undoubtedly prompted the Seattle Police department's multiple statements regarding why police allow protesters to block city streets, cited heavily by all parties in the briefing. The fiercely emotional reaction of these angry citizens is contrasted with the equally emotional reaction of those who advocate for extensive First Amendment rights. In this climate of political polarization, and in the face of a perceived increase in frequency of street-blocking demonstrations, it is reasonable for the City Attorney to feel a need to explain the filing decisions he makes on these issues.

The claim that the City Attorney's essay is likely to influence the jury pool in this case is also without merit. At oral argument, Linet's attorney argued that the "inflammatory" language of the article is likely to unduly influence the jury pool. The fact that the Op-Ed was submitted at the time charges were *filed* mitigates the potential impact of the piece on any jury pool. A different situation would be presented if the Op-Ed appeared on the eve of, or even during, the trials in these cases. Moreover, the impact the essay has on any particular potential juror can likely be remedied during jury selection.

C. Motion for Additional Discovery

Linet argues that the discovery provided by the City Attorney's office in response to requests for information regarding the extent of police attempts to influence the charging process, internal deliberations on the charging decision before, during and after police interference, internal deliberations on drafting and publishing the opinion letter and prosecutor communications with the Seattle Times. The City Attorney's office responded with a number of communications in response to the discovery request.[10] Many of these responsive

[10] At oral argument, the parties referred to dozens of pages of "Bates" numbered discovery. Only a small portion of these have been provided to the court as attachments to the briefing.

documents were redacted, claiming that they contained attorney work product. Linet requests *in camera* review to determine the validity of the work product claims.

In order to be entitled to *in camera* review of withheld discovery, defendants must demonstrate at least "some evidence" of vindictiveness in the charging decision. Additional discovery should only be granted in "rare" cases. United States v. Adams, 870 F.2d 1140, 1145 (6th Cir. 1989). Defendants must also demonstrate that the information they are seeking is "material" to the issues raised. State v. Mak, 105 Wn.2d 692, 704 (1986).

Here, internal deliberations on the drafting and publishing on the opinion letter are completely irrelevant to this case. Communications with Seattle Times about timing of publication are also immaterial. Therefore, the request for *in camera* review of documents related to those issues is denied.

A closer question is presented regarding the possibility of a vindictive prosecution claim based upon the potential influence of the police on charging decisions. The only emails related to this issue contain a mere "inquiry" from an officer regarding the status of whether charges were to be filed. This fact of this inquiry, by itself, is insufficient to support a claim of prosecutorial vindictiveness or undue influence that would require dismissal of the charges under CrR 8.3.

The unprofessional remarks of individual officers made during the response to the protests are also insufficient, on their own, to support a claim of prosecutorial vindictiveness. The officers' remarks are content neutral in that they do not appear to reference the political issue of the protest, but rather seem to be an expression of frustration at their perceived inability to clear the streets. However, it could be possible to infer that the officers

were biased against freedom of expression and political protest in general. By themselves, however, these comments were too vague to support a claim of vindictiveness.

In the May protests, the police reports indicate that *eleven* individuals were arrested from the street after refusing to obey the officers' orders to clear the area. These individuals locked arms, and refused to move. Only *seven* of these individuals were charged with pedestrian interference. This court is unable to discern from the police reports any difference whatsoever in the behavior of the seven who were charged and the four who were not charged.

This fact, taken together with the remarks made by police officers in the body cam video, could theoretically give rise to a claim of prosecutorial vindictiveness *if* the discovery related to the charging decisions reveals a discriminatory purpose or intent to charge some street protesters but not others. This possibility entitles the defendants to an *in camera* review of the redacted correspondence provided to defendants.

Thus, this court orders the City Attorney to provide redacted copies of the discovery on this issue that has been provided to the defendants, along with a sealed copy of the unredacted discovery for the court to review. If any of the reacted discovery is not properly characterized as work product or privileged material, or if any of the discovery reveals evidence that could be used to support a claim of prosecutorial vindictiveness, the court will order unredacted portions to be provided to defense counsel. These documents should be provided to the court in advance of the March 18, 2019 pretrial hearing.

Dated this 6th day of March, 2019.

Judge Pro Tem Catherine M. McDowall

JUDICIAL EVALUATION COMMITTEE

September 18, 2020

The Honorable Lorena González
President, Seattle City Council
Seattle City Hall, 2nd Floor
Seattle, WA 98104

The Honorable Lisa Herbold
Chair Public Safety Committee, Seattle City Council
Seattle City Hall, 2nd Floor
Seattle, WA 98104

Dear Council President González and Chair Herbold:

We are members of the Judicial Evaluation Committee representing several of the local Minority Bar Associations, the Seattle City Attorney's Office and The Public Defender Association. We write in support of the Mayor's appointment and request the City Council's confirmation of Pro Tem Judge Catherine McDowall to fill the current vacancy on the Seattle Municipal Court.

Pro Tem Judge McDowall has been a judge on the Seattle Municipal Court and King County District Court for over seven years. She demonstrated to the committee that she exhibits the criteria that we were asked to consider as part of our evaluation:

- Requisite Legal Knowledge – criminal procedure, evidence, jury trial experience
- "Hit the ground running" – Pro-tem or judge experience
- Diversity of work experience and innovation to support court's goal on criminal justice reform
- Fair and open-minded and good temperament
- Respected in the community and legal profession
- Team player and good communicator
- Experience in restorative justice principles
- Highest integrity
- Demonstrated ability to show respect and empathy in the courtroom

Also, pursuant to Ordinance 121698, we considered the candidates application materials, including bar association ratings from the King County Bar Association and the Minority Bar Associations in our evaluation. Pro Tem Judge McDowall received a rating of Well Qualified from the King County Bar Association, Qualified from the Loren Miller Bar Association, and Exceptionally Well Qualified from the Washington Women Lawyers.

The Committee recommends Pro Tem Judge McDowall be appointed and confirmed to the Seattle Municipal Court bench. She would be an asset to the court and will further the court's commitment and leadership to address issues of institutional racism in the criminal justice system and engage in reform efforts.

Thank you for your consideration.

Signed:

JUDICIAL EVALUATION COMMITTEE

Betsy A. Crumb
Betsy A. Crumb
Chair, Judicial Evaluation Committee, Washington Women Lawyers

Adrienne Wat
Asian Bar Association of Washington, Board Member

James F. Johnson
President, Loren Miller Bar Association

Shayna Israel
QLaw of Washington, Board Member

Cheryl Lee
Cheryl Lee
Past President, Korean American Bar Association of Washington

Prachi Dave
Prachi Dave
Legal Director, Public Defender Association and Co-Chair Community Police Commission

Stephanie P. Dikeakos
Stephanie Dikeakos
Assistant City Attorney, Seattle City Attorney's Office

File #: CB 119893, **Version:** 1

CITY OF SEATTLE

ORDINANCE _____

COUNCIL BILL _____

AN ORDINANCE relating to the Seattle whistleblower protection code; expanding the definition of "report" in the City of Seattle's whistleblower protection ordinance to include reporting to the Office of Inspector General for Public Safety; amending Section 4.20.805 of the Seattle Municipal Code.

WHEREAS, in 1990, 1991, 1992, 1994, 1996, and 2013, the City Council has recognized the important public policy inherently expressed by the City's whistleblower protection provisions in Subchapter III of Seattle Municipal Code Chapter 4.20; and

WHEREAS, it is in the public interest to encourage public employees to report instances of improper governmental action in order to give the governmental entity the opportunity to correct improper governmental actions; and

WHEREAS, the most effective way to encourage public employees to report improper governmental action is to provide an effective whistleblower protection program that includes a clear reporting process and effective protection from retaliation; and

WHEREAS, in 2017 the City created the Office of Inspector General for Public Safety (OIG) as part of the police accountability ordinance, Ordinance 125315, and therein charged that office with helping to "ensure the fairness and integrity of the police system as a whole in its delivery of law enforcement services by providing civilian auditing of the management, practices, and policies of SPD and OPA and oversee ongoing fidelity to organizational reforms implemented pursuant to the goals of the 2012 federal Consent Decree in United States of America v. City of Seattle, 12 Civ. 1282 (JLR)" for "ensuring constitutional, accountable, effective, and respectful policing" (Ord. 125315, 3.29.010.B); and

WHEREAS, OIG is also authorized under the accountability ordinance to "conduct audits and reviews for any areas that may (a) involve potential conflicts of interest; (b) involve possible fraud, waste, abuse, inefficiency, or ineffectiveness; (c) undermine accountability or be unethical; or (d) otherwise compromise the public's trust in the police or the criminal justice system" (Ord. 125315, 3.29.200.G); and

WHEREAS, OIG provides independent systemic oversight over the Seattle Police Department; and

WHEREAS, OIG in the course of its oversight activities interviews employees who may have knowledge of potential misconduct and wish to report it; and

WHEREAS, reporting to OIG does not currently afford employees the protections of the City's whistleblower protection provisions, which can have a chilling effect on employees' willingness to come forward; and

WHEREAS adding OIG as a covered entity for reporting under the whistleblower protection provisions furthers the public policy goals of the City; NOW, THEREFORE,

BE IT ORDAINED BY THE CITY OF SEATTLE AS FOLLOWS:

Section 1. Section 4.20.805 of the Seattle Municipal Code, enacted by Ordinance 124362, is amended as follows:

4.20.805 Definitions

As used in Sections 4.20.800 through 4.20.880, the following terms are defined as follows:

* * *

"Report" means:

A. Reporting any assertion of improper government action to the Executive Director including reporting violations of the Ethics and Elections Codes;

B. Reporting any assertion of improper government action to an employee's supervisor, manager, officer or appointing authority or director;

C. Reporting any assertion of sexual harassment to the employee's supervisor, Equal Employment

Officer, agency head, or other government official as set out in the City's procedure for reporting sexual harassment complaints;

D. Reporting alleged violations of the Fair Employment Practices ordinance or the Health Insurance Portability and Accountability Act (HIPAA) to the Office for Civil Rights;

E. Reporting alleged misconduct by Seattle Police Department personnel to the City of Seattle ((~~Police~~)) Office of ((~~Professional~~)) Police Accountability;

F. With respect to the Seattle Police Department, including the Office of Police Accountability, reporting any assertion of improper government action to the Office of Inspector General for Public Safety;

G. Reporting alleged violations of the Code of Judicial Conduct to the Washington State Commission on Judicial Conduct;

((~~G.~~)) H. Reporting alleged violations of criminal laws to any law enforcement agency;

((~~H.~~)) I. Reporting when the employee believes in good faith that a crime is about to be committed, to any law enforcement agency, agency head, manager or supervisor;

((~~I.~~)) J. Reporting if an employee is, in good faith, seeking advice, counsel or opinion on their rights and responsibilities under this subchapter to determine whether to make a report under this chapter;

((~~J.~~))K. Reporting outside of City government if 30 days have passed since the employee made a written report pursuant to this chapter; or

((~~K.~~))L. Reporting in an emergency, to any person who has the ability to address the danger or risk, where the employee believes in good faith that there is a substantial and specific danger or risk of serious injury, illness, peril, or loss to any person. No emergency under this subsection exists where prompt attention and reporting under this subchapter by the employee could have avoided the perceived need to report immediately.

* * *

Section 2. This ordinance shall take effect and be in force 30 days after its approval by the Mayor, but if not approved and returned by the Mayor within ten days after presentation, it shall take effect as provided by Seattle Municipal Code Section 1.04.020.

Passed by the City Council the _____ day of _____, 2020, and signed by me in open session in authentication of its passage this _____ day of _____, 2020.

_____

President _____ of the City Council

Approved by me this _____ day of _____, 2020.

_____

Jenny A. Durkan, Mayor

Filed by me this _____ day of _____, 2020.

_____

Monica Martinez Simmons, City Clerk

(Seal)

SUMMARY and FISCAL NOTE*

Department:	Dept. Contact/Phone:	CBO Contact/Phone:
Legislative	Lish Whitson/206-615-1674	N/A

** Note that the Summary and Fiscal Note describes the version of the bill or resolution as introduced; final legislation including amendments may not be fully described.*

1. BILL SUMMARY

Legislation Title:
AN ORDINANCE relating to the Seattle whistleblower protection code; expanding the definition of "report" in the City of Seattle's whistleblower protection ordinance to include reporting to the Office of Inspector General for Public Safety; amending Section 4.20.805 of the Seattle Municipal Code.

Summary and background of the Legislation:
This bill would amend the definition of "reporting" in the whistleblower protection code (Subchapter III of Chapter 4.20 of the Seattle Municipal Code) to provide whistleblower protections for reporting improper governmental actions to the Office of Inspector General for Public Safety (OIG). The OIG is charged with auditing and reviewing activities of the Seattle Police Department and the Office of Police Accountability and may also audit other City agencies on matters related to policing and criminal justice. During its auditing activities, it may hear reports of improper governmental acts. This bill would include reporting of improper governmental actions about the Seattle Police Department or Office of Police Accountability to the OIG to the list of reporting for which employees may receive whistleblower protection.

Including OIG may encourage employees to come forward who might otherwise not report improper governmental actions. Although there are other routes to report for whistleblower protections, OIG by virtue of its audits and interviews is placed in situations where such reports may naturally arise. Adding OIG to the list of entities to whom inappropriate governmental actions can be reported under the whistleblower protection code is estimated to result in up to three reporting occurrences per year.

The Seattle Ethics and Elections Commission would review any potential instance of retaliation against any employee who makes one of those reports. This is likely to be a subset of any employees reporting instances of reporting of an improper governmental act.

2. CAPITAL IMPROVEMENT PROGRAM

Does this legislation create, fund, or amend a CIP Project? ___ Yes __X__ No

3. SUMMARY OF FINANCIAL IMPLICATIONS

Does this legislation amend the Adopted Budget? ___ Yes __X__ No

Does the legislation have other financial impacts to the City of Seattle that are not reflected in the above, including direct or indirect, short-term or long-term costs?

No

Is there financial cost or other impacts of *not* implementing the legislation?

No

4. OTHER IMPLICATIONS

a. Does this legislation affect any departments besides the originating department?
The legislation would incorporate the oversight authority that is invested in the Office of Inspector General into Seattle's Whistleblower Protection Ordinance, which is overseen by the Seattle Ethics and Elections Commission. The protections would be extended to reporting made regarding the Seattle Police Department or Office of Police Accountability. Any increase in reporting would occur with those departments.

b. Is a public hearing required for this legislation?
No

c. Does this legislation require landlords or sellers of real property to provide information regarding the property to a buyer or tenant?

No

d. Is publication of notice with *The Daily Journal of Commerce* and/or *The Seattle Times* required for this legislation?

No

e. Does this legislation affect a piece of property?

No

f. Please describe any perceived implication for the principles of the Race and Social Justice Initiative. Does this legislation impact vulnerable or historically disadvantaged communities? What is the Language Access plan for any communications to the public?

None identified.

g. If this legislation includes a new initiative or a major programmatic expansion: What are the specific long-term and measurable goal(s) of the program? How will this legislation help achieve the program's desired goal(s).

Not applicable

List attachments/exhibits below: None

SEATTLE CITY COUNCIL
CENTRAL STAFF

September 18, 2020

M E M O R A N D U M

To: Public Safety and Human Services Committee
From: Lish Whitson, Analyst
Subject: Council Bill 119893: Whistleblower protections for reports to the Office of the Inspector General

On Tuesday, September 22, the Public Safety and Human Services Committee will consider Council Bill (CB) 119893, which would amend Seattle's whistleblower protection code (Subchapter III of Chapter 4.20 of the Seattle Municipal Code) to include protections for employees who report improper governmental actions by the Seattle Police Department (SPD), including the Office of Police Accountability (OPA), to the Office of the Inspector General for Public Safety (OIG). This memorandum describes the existing whistleblower protection code and the effect of adding OIG to the code.

Whistleblower Protection Code

The whistleblower protection code provides City employees with the right to be free from retaliation when they report improper governmental actions. Key to the code are the definitions of "report" and "improper governmental action." The proposed bill would amend the definition of "report" to include testimony about improper governmental action by the Seattle Police Department to OIG.

Under Section 4.22.805, "report" is defined as:

A. Reporting any assertion of improper government action to the Executive Director including reporting violations of the Ethics and Elections Codes;

B. Reporting any assertion of improper government action to an employee's supervisor, manager, officer or appointing authority or director;

C. Reporting any assertion of sexual harassment to the employee's supervisor, Equal Employment Officer, agency head, or other government official as set out in the City's procedure for reporting sexual harassment complaints;

D. Reporting alleged violations of the Fair Employment Practices ordinance or the Health Insurance Portability and Accountability Act (HIPAA) to the Office for Civil Rights;

E. Reporting alleged misconduct by Seattle Police Department personnel to the Seattle Police Office of Professional Accountability;

F. Reporting alleged violations of the Code of Judicial Conduct to the Washington State Commission on Judicial Conduct;

G. Reporting alleged violations of criminal laws to any law enforcement agency;

H. Reporting when the employee believes in good faith that a crime is about to be committed, to any law enforcement agency, agency head, manager or supervisor;

I. Reporting if an employee is, in good faith, seeking advice, counsel or opinion on their rights and responsibilities under this subchapter to determine whether to make a report under this chapter;

J. Reporting outside of City government if 30 days have passed since the employee made a written report pursuant to this chapter; or

K. Reporting in an emergency, to any person who has the ability to address the danger or risk, where the employee believes in good faith that there is a substantial and specific danger or risk of serious injury, illness, peril, or loss to any person. No emergency under this subsection exists where prompt attention and reporting under this subchapter by the employee could have avoided the perceived need to report immediately.

Key to this definition is the concept of “improper governmental action.” The same section defines improper governmental action as follows:

"Improper governmental action"

A. Improper governmental action means any action by an employee that is undertaken in the performance of the employee's official duties, whether or not the action is within the scope of employment, that:
   1. Violates any federal, state, county or City statute, ordinance or rule;
   2. Creates a substantial or specific risk of serious injury, illness, peril, or loss, that is a gross deviation from the standard of care or competence that a reasonable person would observe in the same situation;
   3. Results in a gross waste of public funds or resources; or
   4. Prevents the dissemination of scientific opinion or alters technical findings without scientifically valid justification, unless disclosure is legally prohibited. This provision is not meant to preclude the discretion of agency management to adopt a particular scientific opinion or technical finding from among differing opinions or technical findings to the exclusion of other scientific opinion or technical findings.

B. Improper governmental action excludes:
   1. Personnel actions, including but not limited to: employee grievances, complaints, appointments, promotions, transfers, assignments, reassignments, reinstatements, restorations, reemployments, performance evaluations, reductions in pay, dismissals, suspensions, demotions, reprimands, violations of collective bargaining or civil service laws, or alleged violations of agreements with labor organizations under collective bargaining, or any action that may be taken under RCW Chapters 41.08 , 41.12 , 41.14 , 41.56 , 41.59 , or 53.18 or RCW 54.04.170 and 54.04.180 .
   2. A properly authorized City policy, reasonable expenditure or activity merely because an employee dissents from the City policy or considers the expenditure unwise.

If an employee makes a report as defined in the code, they may be protected from retaliation. The Seattle Ethics and Elections Commission (SEEC) Executive Director is charged with reviewing complaints of retaliation. The Executive Director conducts an inquiry and, if the complaint falls within the whistleblower protection code, investigates the alleged retaliation. If the Executive Director has reasonable cause to believe that retaliation has occurred the employee has the option to (1) pursue settlement with the City or (2) file a civil case in Superior Court. The SEEC Executive Director may file a complaint alleging retaliation with the Seattle Hearing Examiner. Relief and damages vary depending on the venue and facts of the case.

Council Bill 119893

The OIG is charged with auditing and reviewing activities of SPD and the OPA and may also audit other City agencies on matters related to policing and criminal justice. During its auditing activities, OIG may hear reports of improper governmental acts. CB 119893 would amend the definition of "report" by adding "reporting any assertion of improper governmental action" related to the SPD to OIG. This would provide whistleblower status to employees who report threats to public safety or violations of City, State, or Federal Law caused by the Seattle Police Department. Providing such protection to employees who make reports will better enable the OIG to do its work.

Next Steps

If the Public Safety and Human Services Committee acts on CB 119893 at its September 22 meeting, the legislation may be considered at a City Council meeting as early as September 29.

cc: Dan Eder, Interim Director
Aly Pennucci, Supervising Analyst

Legislation Text

File #: Inf 1686, **Version:** 1

An analysis of court imposed monetary sanctions in Seattle Municipal Courts

Seattle
Office for Civil Rights

Jenny A. Durkan, Mayor
Mariko Lockhart, Director

Date:	**7.28.2020**
To:	Council President M. Lorena González & Councilmember Lisa Herbold, Chair of Public Safety and Human Services Committee
From:	Mariko Lockhart, Director, Seattle Office for Civil Rights
Subject:	**Monetary Sanctions Report**

The attached report, *An Analysis of Court Imposed Monetary Sanctions in Seattle Municipal Courts, 2000-2017*, was commissioned by the Seattle Office for Civil Rights (SOCR) in response to Council Resolution 31367, which established the Reentry Workgroup and requested an inventory and assessment of the City's current imposition and collections of fines and fees for criminal violations and infractions as well as the impact of such on reentry. This report was co-authored by Dr. Alexes Harris and Dr. Frank Edwards. Data was provided by Seattle Municipal Court's Research, Planning and Evaluation Group. Included in this report's recommendations is a call for an examination of the value of imposing fines and fees altogether, which SOCR strongly encourages the City undertake as part of our ongoing efforts to reshape public health and safety in Seattle.

In sharing previous drafts of the report with SMC, SOCR has engaged in thoughtful dialogue with SMC, the report authors, as well as Reentry Workgroup representatives from Columbia Legal Services, about differences in terminology, methodology, and some key findings of the report. We are grateful for the expertise provided by the report authors, our colleagues at SMC, and consultation provided by Columbia Legal Services, and their willingness to engage throughout this process. While there may be differing opinions regarding some of the findings, there is also agreement. Most of the monies collected by SMC are from traffic fines and fees, and Black individuals and people of color disproportionately bear the financial burden, due to the nature of the tickets they were given by traffic and parking enforcement.

While SOCR is pleased that the report found that SMC imposes the lowest median fine and fee amounts in almost all sanction categories compared to other limited jurisdiction courts in Washington, fines and fees are still harmful to the disproportionately Black and Brown individuals who are involved with the Court. SOCR recognizes that when it comes to the disparate and harmful impacts of parking and traffic infractions, we must also pursue solutions at the legislative and enforcement levels since SMC is unable to suspend infraction-related monetary sanctions required under local and state statutes once a ticket is issued.

There is still room to make changes in how the City approaches monetary sanctions, from how fines and fees are levied through their collection. While the report doesn't focus on the impact of fines and fees on reentry, the report does highlight the need to evaluate how the City can invest in upstream approaches to reduce the disproportionate impact of monetary sanctions on Black communities. While SMC monetary sanctions may not cause later incarceration, there is a correlation that warrants further examination.

We look forward to the outcomes of the work being done through the City and King County partnership with PolicyLink's Cities and Counties Fine and Fees Justice that will examine how to address certain unjust fines and fees. Additionally, as stated above, among the report's recommendations is for the City and SMC to interrogate the penological goals of imposing any monetary sanctions at all along with statewide stakeholders. We include parking and trafficking fines under this umbrella since like criminal sanctions, these fines are also used to enforce laws. This report compels us to explore more equitable means to deter behaviors. SOCR would like to elevate this deeply insightful recommendation from Drs. Edwards and Harris and encourages the City at large to answer this question as part of our current efforts to re-envision community health and safety.

Racial and other disparities are found at every level of our criminal legal system from parking and law enforcement to prosecution to the Court. Changes at any level of our criminal legal system will be felt throughout the whole system. For instance, as the City reinvests law enforcement dollars into non-punitive forms of public health and safety, the caseloads of the City Attorney's Office and SMC, as well as the City's use of jail beds, will most likely shrink, potentially leaving more dollars for reinvestment into community-owned public health and safety.

We must work with communities most impacted by our criminal legal system to evaluate the role of our Court and prosecutors in conjunction with our discussions around policing to avoid unintended consequences and missed opportunities as we build a public safety approach that is just, safe, and equitable for all communities in our city.

An Analysis of Court Imposed Monetary Sanctions in Seattle Municipal Courts, 2000-2017.

Report Prepared For:

The City of Seattle, Office for Civil Rights
7/28/2020

Prepared by:

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Acknowledgements: We are grateful to the assistance of Caedmon Magboo Cahill, City of Seattle Office for Civil Rights for her support in framing this study and to Rich Cook, Seattle Municipal Court's Research, Policy and Planning Group for his assistance with accessing the data used in this report.

I. Lists of Tables and Figures

II. Introduction

While the laws, policies and court practices vary, each state in the United States imposes some sort of scheme to sentence law violators to justice system fees, fines related to specific offenses, and restitution to directly or indirectly reimburse victims, in addition to a host of costs related to non-full payment. Many states have legislatively established "mandatory" fines or fees, where judges have no discretion in whether or not to sentence people, even those deemed indigent.[i] Over the past twelve years, research has emerged to outline local and state level practices, documenting the varying dimensions of court mechanisms used to assess the costs, monitor repayment and non-payment, and punish people who do not pay.[ii] This research has examined the consequences of court imposed fines and fees on the lives and families of people who owe the debt, the practices by which local jurisdictions collect the penalties, and the disparate effects of monetary sanctions for youth, communities of color and people who are poor.[iii] Research has also begun to give attention to justice practices related to the imposition of fines and fees, such as the privatization of services and products within justice systems and state revenue generation foci and practices.[iv]

In this report, we use an expansive definition of legal financial obligations (LFO), which is inclusive of all financial debts imposed by a court because of a criminal charge or infraction. We use the term LFO interchangeably with the term of monetary sanctions. The definition we use is broader than typical definitions that narrowly focus on criminal cases only. However, in the eyes of debtors, debt arising from both traffic and non-traffic infractions can have similar consequences as can debt arising from criminal cases. Our goal in this report is to capture the *total* impacts of the broad system of monetary sanctions in Seattle. While our analysis focuses on data from the Seattle Municipal Court, this system depends on the actions wide range of institutions, including the court itself, the Seattle Police Department, the City Attorney's Office, and others. As such, our results and interpretations may differ from those that use more narrow criteria to define legal financial obligations. Our analyses treat LFOs as inclusive of all monetary sanctions that individuals may incur because of cases processed in Seattle Municipal Court.

Legal Financial Obligations, as defined in Washington State statute include the fines, fees, costs imposed by the court as the result of a criminal convictions. Washington State's Legal Financial Obligations are mandated by RCW 9.94A.760.[v] Specific fines and fees are embedded throughout the RCW. The mandatory LFOs include: a Victim Penalty Assessment (VPA) which imposes $500 for each felony or gross misdemeanor conviction and a $250 fee for each misdemeanor conviction (RCW 7.68.035). The DNA Collection Fee imposes a one-time fee of $100 for a crime specified in RCW 43.43.754 and must be sentenced (this is not mandatory for persons with mental health conditions). Furthermore, restitution shall be ordered when a person is convicted of a felony offense resulting in injury, damage or loss of property. Some LFOs are crime specific fines and are mandatory based on type of offense (e.g., sex offense). Other fees and costs such as, criminal filing fee, conviction fee or jury fee shall not be imposed if a person is deemed indigent or has a mental health condition.

We have been asked by the Seattle Office for Civil Rights to conduct an analysis of the sentencing and collection of fines and fees by the Seattle Municipal Court (SMC). It is

important to note that as national, as well as Washington specific research, has shown, the sentencing and citation of fines and fees is just one discretionary point within the overall system of monetary sanctions. This punishment schema entails several discretion points, including, citations by police officers, sentencing by court officers, management of debt by court clerks and private collection agencies, judicial and probationary supervision and punishment of people who owe court debt. As our analyses illustrate, many of the cases that come before the SMC have been initiated not by Seattle Municipal Court judges, but instead via traffic violations issued by Seattle police and parking enforcement officers. As such, our concluding discussion of policy implications suggests a broad range of officials, including the Seattle Police Department and SMC, to collectively think broadly about this system of monetary sanctions and how best to alleviate the consequences for people who are unable to pay the debt and who are processed through multiple discretion points that lead to a cumulative negative effect.

Report Aims

The aim of this report is to outline four dimensions related to the citation, sentencing and management of fines and fees by the Seattle Municipal Court. We aim to better understand the type of SMC cases associated with LFO sentences and the time it takes for people to pay off the debt. We are also interested in how the debt might matter for subsequent criminal court involvement. Might carrying LFO debt increase individuals' contact with superior courts in Washington State? Furthermore, a key outstanding question about LFOs is the extent to which there may be racial and ethnic differences in citations, sentencing, ability to pay the debt and subsequent court contact. Also, of interest is how the City of Seattle Municipal Court's LFO sentencing, and the duration of debt and ability of citizens to pay that debt back, compares to other cities in Washington State. From this set of questions, we have arrived at the following dimensions for analysis:[vi]

1. Extent and characteristics of unpaid debt
2. Impact of SMC fines and fees on people who cannot afford them
3. Exploration of racial disparities in traffic and non-traffic infractions
4. Comparison of the City of Seattle LFO process with other cities in WA State

Summary of Key Findings:

In what follows we provide a detailed analysis of the scope of fines and fees sentenced and collected by Seattle Municipal Court through 2000-2017. In sum, we present the following key findings from our data analysis:

1. There has been a remarkable decline in cases filed in Seattle Municipal Courts between 2000 – 2017, even as the population size of Seattle increased during this time period.

2. People sentenced to criminal traffic cases tended to have their LFO accounts open (not fully paid) for longer periods of time relative to other types of traffic cases.

3. For each class of case, Black men and women are significantly more likely than their peers to be sentenced to incarceration through a Washington superior court following a paid Seattle Municipal Court legal financial obligation sentence (SMC LFO).

4. Black men and women are more likely to be incarcerated following an unpaid SMC LFO than are any other racial or ethnic group.

5. People of color have a higher likelihood than White people to be charged with a DWLS3 following a Seattle Municipal Court legal financial obligation sentence. This is especially pronounced for Black Seattle drivers.

III. Data and Methods

All cited or convicted cases from 2000-2017 were provided by the Seattle Municipal Court via the JIS (District and Municipal Court Judicial Information System).[vii] This data system assists court officers and clerks in managing and reporting Washington State's district and municipal court cases. All analyses were conducted by Frank Edwards, using the R statistical programming language. Comparisons to other jurisdictions use data from the Washington Administrative Office of the Courts (AOC) on LFO sentencing in all other Washington Municipal Courts between 2000 and 2014.

Note that the analyses below exclude a very small number of cases in which total assessed LFOs equaled over one million dollars. The analyses also exclude a small number of felony cases recorded in the data. Population data are obtained from the 2000 and 2010 census, and intervening years are imputed through linear interpolation.

While each case can be assessed multiple LFOs (mean LFOs per case with assessed LFOs in sample = 6.6), all reported LFO figures are aggregated to the case-level to ensure comparability across categories of violations and between SMC and other courts of limited jurisdiction. We compute three values to describe the legal financial obligations assessed for each case: initial amount ordered, amount owed after court adjustment, and amount paid.

Table 1. Median annual total SMC LFOs by case type (in 2018 inflation adjusted dollars)

Case type	Originally ordered	After court adjustment	% Adjusted from Original	Paid	% Paid from Adjusted
Infraction Traffic	$ 24,467,354	$ 9,471,204	39%	$ 8,080,052	85%
Infraction Non-Traffic	$ 824,678	$ 406,969	49%	$ 283,779	70%
Criminal Traffic	$ 3,598,035	$ 579,825	16%	$ 528,681	91%
Criminal Traffic: DUI	$ 4,033,011	$ 642,556	16%	$ 543,827	85%
Criminal Non-Traffic	$ 12,041,164	$ 356,704	3%	$ 304,264	85%

The initial **amount ordered** is a simple sum of all ordered LFOs at the case-level prior to any adjustment by the court. The **amount paid** is a sum of the total amount paid on LFOs at the case-level. The **amount owed** after court adjustment is computed according to the following rules:

- If the current amount due on an account is recorded as zero dollars, the adjusted amount is equal to the paid amount
- If the current amount due on an account is greater than zero dollars, the adjusted amount is equal to the current amount owed plus the total paid.

Each of these values is inflation adjusted to January 2018 dollars using the consumer price index to ensure comparability over time.

Race, Ethnicity and Surname Analysis

SMC does not collect race/ethnicity for subject to LFOs. Instead, it relies on and reports data collected by police, and these data do not report Latinx ethnicity. To disaggregate Latinx people from non-Hispanic white people, and to recover information on some cases where race/ethnicity data is missing (about 10 percent of cases), we construct a two-stage imputation process based on a method developed by Imai and Khana[viii]. First we match surnames to Census records that provide estimates of the share of the population with a given surname. Then, we use data on the racial composition of the population in King County, in combination with matched name probabilities, to impute the race/ethnicity of court records missing this demographic information. We classify all records with an imputed posterior probability of Hispanic ethnicity greater than 0.75 (conditional on surname and population composition) as Hispanic, and all those less than or equal to a posterior probability of Hispanic ethnicity to be non-Hispanic. We use a similar procedure for missing data in the AOC records for other Washington courts. Prior to imputation, about 10 percent of cases were missing data on race/ethnicity. After imputation, about 8 percent of cases are missing data on race/ethnicity. Additionally, about 8 percent of cases recorded as white in the initial data are reclassified as Latinx.

Incarceration History

We establish an individual's incarceration history by linking individuals to AOC data on superior court sentences by individual surname and date of birth. This procedure results in about 700,000 individuals with records in both SMC and AOC data. From these matches, we then identify records where an individual was ever sentenced to jail or prison by any superior court in Washington, and identify those cases where SMC LFO sentences preceded a first incarceration sentenced from a superior court based on AOC sentencing dates and SMC filing dates.

Case Types

We use SMC provided case type codes, but distinguish DUI cases from other criminal traffic cases by recoding all cases with a finding of "committed" or "guilty" for any case with a violation code listed as SMC 11.56.020, "Persons under the influence of intoxicating liquor, marijuana, or any other drug." These DUI cases are recoded as a separate category, and are excluded from the criminal traffic case type.

IV. Findings

1. Extent and characteristics of paid and unpaid debt

Our first step to examine legal financial obligations (LFOs) from Seattle Municipal Court (SMC) is to assess the volume of cases, the volume of debt sentenced, and the volume of debt that remains uncollected and under the city's purview. **Figure 1** shows the total volume of cases with ordered LFOs in SMC between 2000 and 2017. The top panel of Figure1 adjusts the total caseload with ordered LFOs to a rate per 1,000 Seattle residents, and the bottom panel displays the caseload as an unadjusted count.

Figure 1. Number of cases with LFOs in Seattle Municipal Court, and cases with LFOs per 1,000 persons by violation type: 2000 – 2017.

Cases have trended downward over this 18-year period. In 2000, SMC handled over 100,000 total cases, and the caseload total was at a minimum in 2017 at about 40,000 cases with ordered LFOs. Because Seattle's population grew substantially over this time period, the per capita rate of LFO orders declined even more rapidly, from a peak of about 200 cases with LFOs per 1,000 residents in 2000 to a minimum of about 50 cases with LFOs per 1,000 residents in 2017, about 25 percent of the rate of LFO debt orders per capita in 2000. Note that across this time period, the overwhelming majority of SMC cases with LFOs were traffic infractions. Non-traffic infractions and criminal cases made up a minority of the remaining cases. In 2017, SMC ordered LFOs in 40,672 cases. **Table 2**. Illustrates that of these cases, 83 percent were traffic infractions,

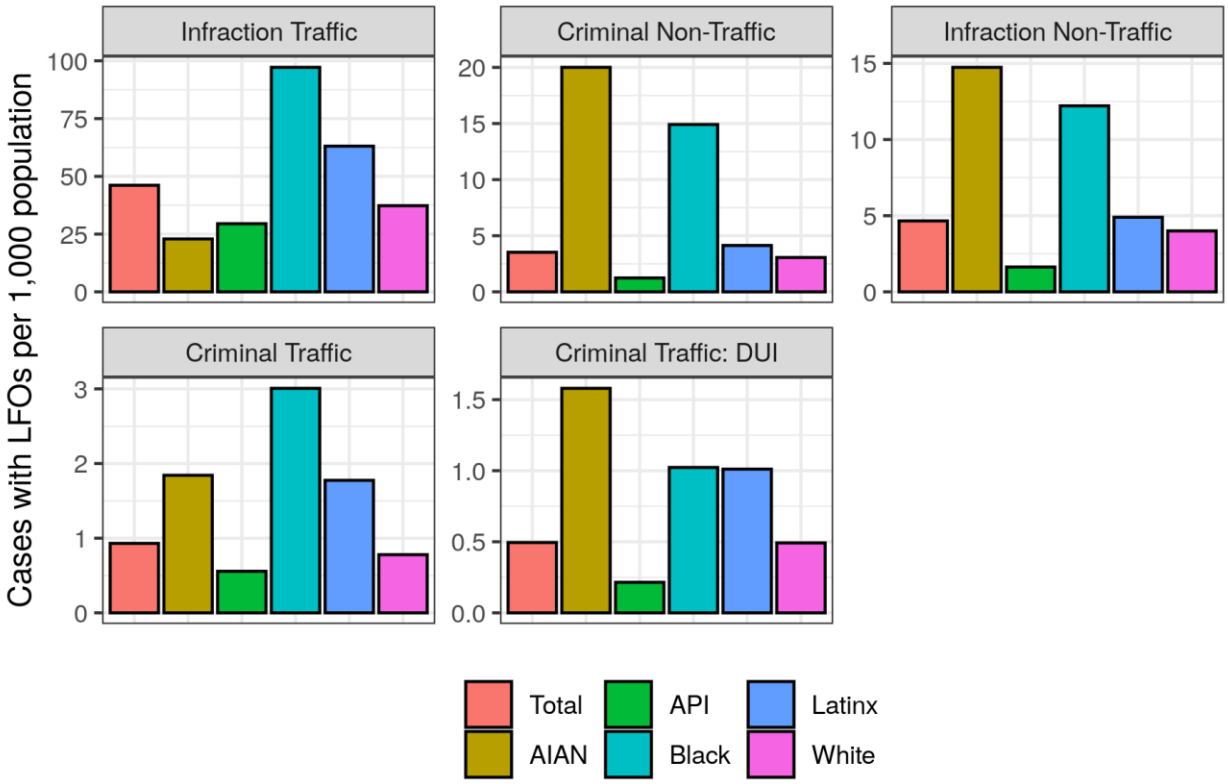
8 percent were non-traffic infractions, 6 percent were non-traffic criminal cases, 2 percent were criminal traffic cases, and 1 percent were DUI cases.

Table 2. Distribution of LFOs by Case Type in SMC, 2000-2017 (N = 40,672).

Case Type	% of Total Cases
Traffic Infractions	83%
Non-Traffic Infractions	8%
Non-Traffic Criminal	6%
Criminal Traffic	2%
DUI	1%

Figure 2 displays the distribution of the SMC LFO caseload across Seattle's population by race/ethnicity using data from cases filed in 2017. Each panel of the figure represents a class of cases. Note the variation in the scale of the y-axis for case rates across categories. For all classes of cases, people of color are ordered LFO debt more frequently than White people in Seattle. In 2017 Black drivers in Seattle were issued 2.6 times more traffic infractions with LFOs per capita than were White drivers. Latinx drivers were issued 1.7 times more traffic infractions than White drivers. American Indians / Alaska Natives were issued LFOs for criminal non-traffic offenses at a per capita rate 6.7 times higher than the rate for white Seattle residents. Non-traffic infraction LFOs were ordered 3.7 times more frequently for American Indians/Alaska Natives than for Whites, and Black Seattlites were issued LFOs for non-traffic infractions at a rate 3.1 times higher than Whites. These disparities are largely a function of case volume, driven by law enforcement activity and population differences.

Figure 2. Cases with LFOs in Seattle Municipal Court per 1,000 population by race/ethnicity, 2017



As shown in **Figure 3**, there are few differences across racial and ethnic groups in initial SMC debt orders and in final amounts ordered after court adjustment for the most common categories of cases. There is more heterogeneity in non-DUI criminal offenses in initial orders, but these offenses are relatively rare in SMC and heterogeneous in composition. Despite some apparent inequalities in high initial sentences for criminal traffic and non-traffic cases, note that after court adjustment, many criminal cases have their balances reduced to near-zero, and initial inequalities are generally reduced or eliminated for criminal LFOs. For DUIs and infraction violations, racial and ethnic differences in median initial and adjusted sentences are minimal.

Coupled with the results in Figure 2, these findings strongly suggest that SMC sentencing practices themselves are not a key driver of racial inequalities in Seattle LFO debt. Instead, the flow of cases into the court appears to be the key driver of population-level inequalities. As explained in the introduction, LFOs are situated within a system of monetary sanctions whereby many are triggered with the citation of tickets by law and parking enforcement. While other LFOs are sentenced directly by court judges. It appears that much of the disproportionate burden of LFOs for people of color managed by SMC stems from the issuing of traffic citations by police and traffic enforcement. When these cases come into the SMC, as with other initial LFO sentences, much of the disparity in sentence amounts are adjusted by SMC court officials.

Figure 3. Median case-level LFO debt originally ordered, after court adjustment, and paid by case type by race/ethnicity, 2015 - 2017

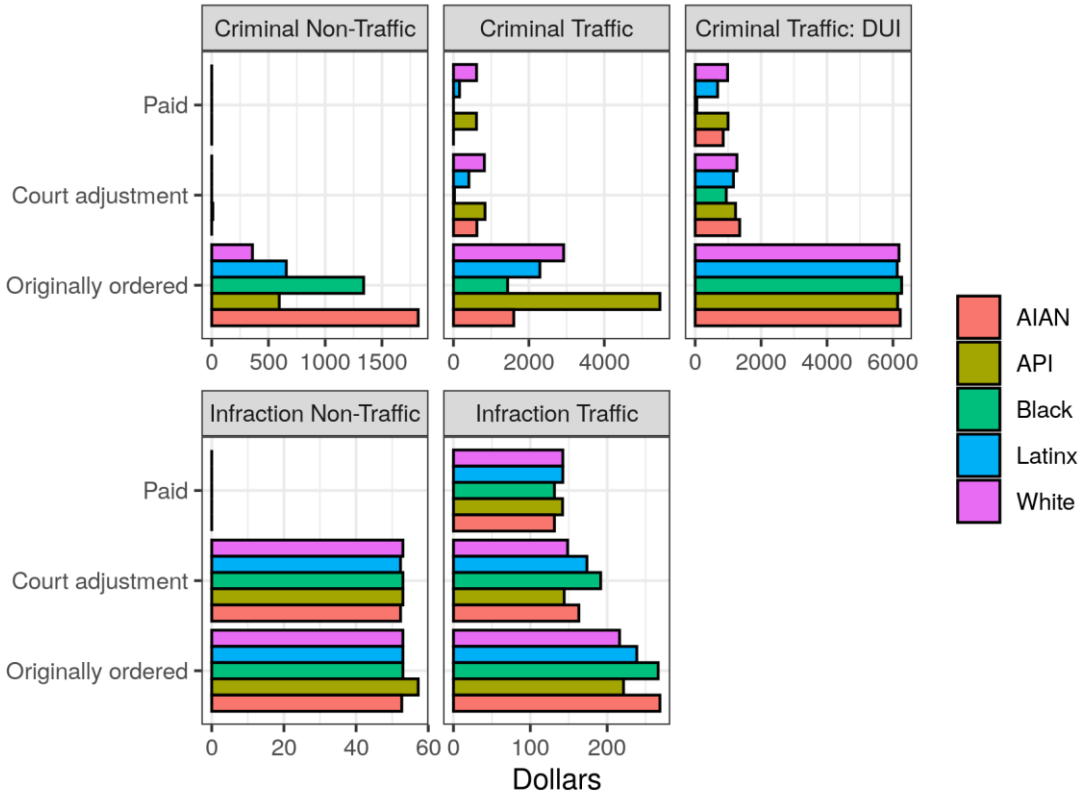


Figure 4 shows how initial orders relate to actual amounts due after court adjustment, and how much of this adjusted balance remained outstanding for accounts filed in 2017. The majority of the initially ordered debt through SMC was for traffic infractions. In 2017, over 10 million dollars of LFOs were ordered through SMC for traffic infractions. After court adjustment, the balance was reduced to 7.2 million dollars, a reduction of about 35 percent from the initial amount ordered. Of this adjusted amount, about 4.8 million was paid before the end of the year in 2017, about 66 percent of the adjusted balance, leaving about 34 percent of the adjusted traffic infraction LFO orders outstanding within this single year of orders. Criminal non-traffic offenses had the second highest total initial LFO amount ordered, at about 5.5 million dollars.

However, the court dramatically reduced this balance due, to an aggregate of about 360 thousand dollars, a reduction of about 93 percent of the initial amount ordered. Of this much reduced balance, most was paid; only about 20 percent of the criminal non-traffic LFO balance was unpaid by the end of 2017. We see similar patterns for criminal traffic (DUI and non-DUI) offenses, with aggregated initial orders of over 2 million reduced by the court to about 400 thousand, a reduction of about 80 percent. For both DUI and other criminal traffic offenses, the majority of the remaining balance was paid within the year. Traffic infractions represent a smaller share of the total debt issued by the court, about 650 thousand in initial orders, and 400 thousand after court adjustment. This reduction is of a similar magnitude to the reductions ordered by the court for traffic infractions, about a 39 percent decrease from initial orders. Of this remainder, much remained unpaid, about 60 percent.

Figure 4. SMC LFO debt originally ordered, after court adjustment, and paid by case type, 2017

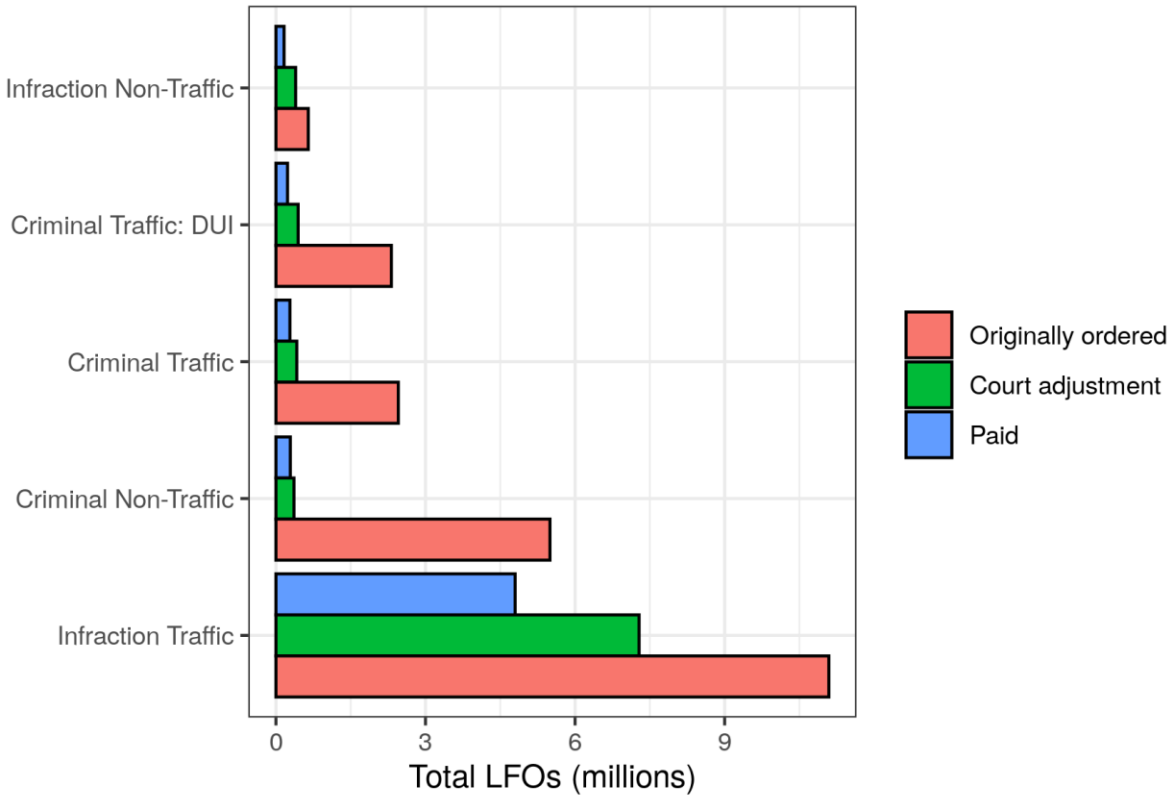


Figure 5 examines how the court adjusted commonly imposed individual legal financial obligations in typical non-DUI criminal cases in 2017. For non-traffic criminal offenses, the average initial fine was about $4900. However, after court adjustment, the average balance due for fines in criminal non-traffic cases was about $10, a dramatic reduction. Other fees and assessments were typically also reduced by large amounts. Restitution, on the other hand, was typically not dramatically reduced by the court. On average across all cases, the ordered restitution amount was ordered about $170, and the average amount after adjustment was about $130. Similar patterns hold for criminal traffic cases. Fines were reduced (on average) by about 90 percent and made up the overwhelming majority of initial LFO orders. Other classes of LFOs were not reduced by the same magnitude, but initial orders were typically quite low.

Figure 6 displays routinely imposed LFOs for both traffic and non-traffic infractions. Note that there are many more types of commonly issued LFOs in these cases than in criminal cases in SMC. Penalties and fines make up the bulk of non-traffic infraction LFO orders, at around $100 each in initial penalties and fines. The court often reduces the penalty order substantially, but infrequently reduces ordered fines in these cases. For both traffic and non-traffic infractions, a battery of fees, surcharges, and assessments are imposed on cases. For example, the most commonly imposed charges include a time payment setup fee, a criminal conviction fee, a trauma care system surcharge, an auto theft prevention assessment, a JIS fee, a default penalty, an accident penalty, a cancellation fee and a deferred finding administrative fee. While each of

these charges is typically a small amount, they are rarely reduced and may add up to substantial total balances.

Figure 5. Average amount ordered, amount ordered after adjustment by court, and amount paid by kind of LFO and by case type: Criminal

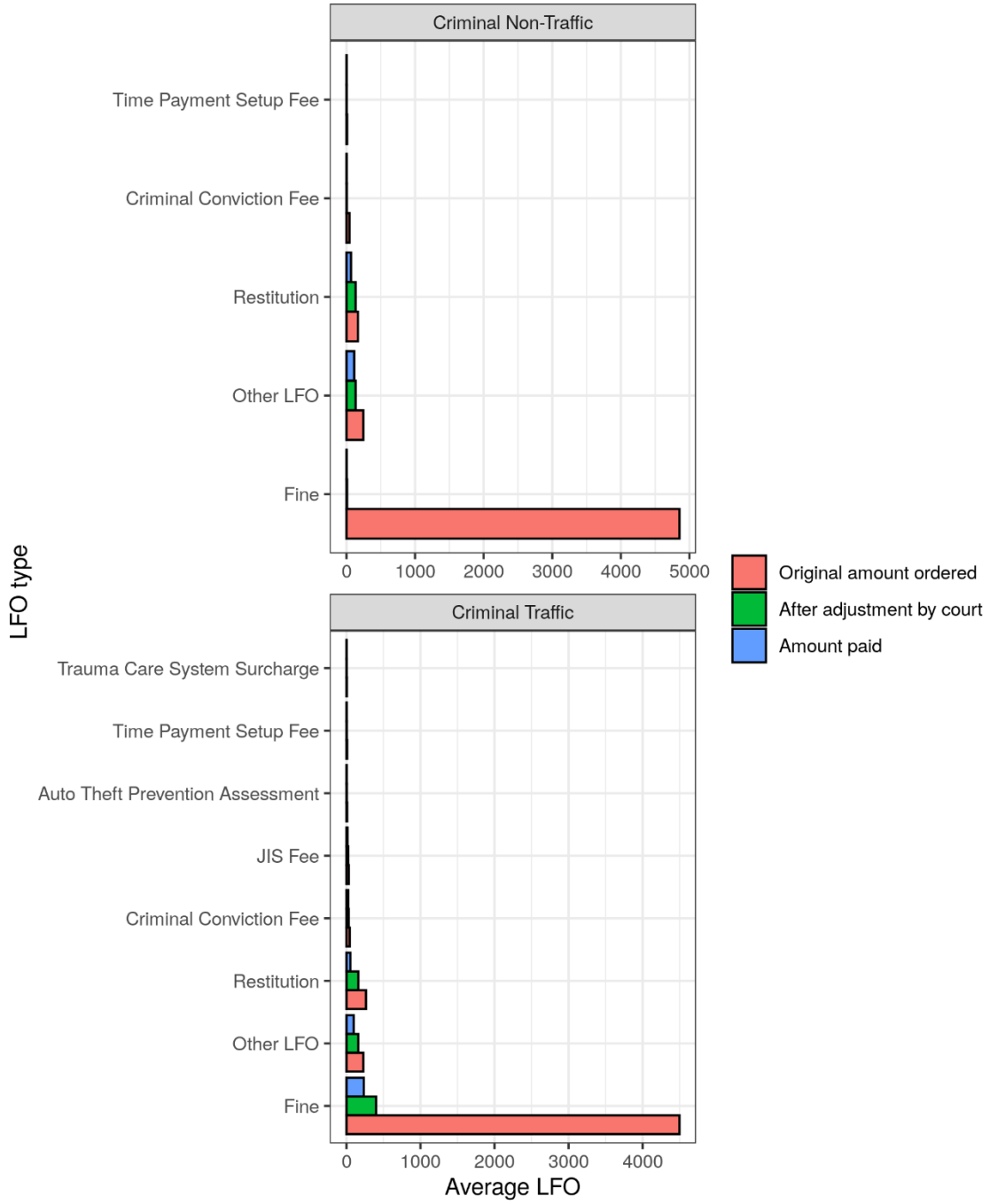


Figure 6. Average amount ordered, amount ordered after adjustment by court, and amount paid by kind of LFO and by case type: Infractions

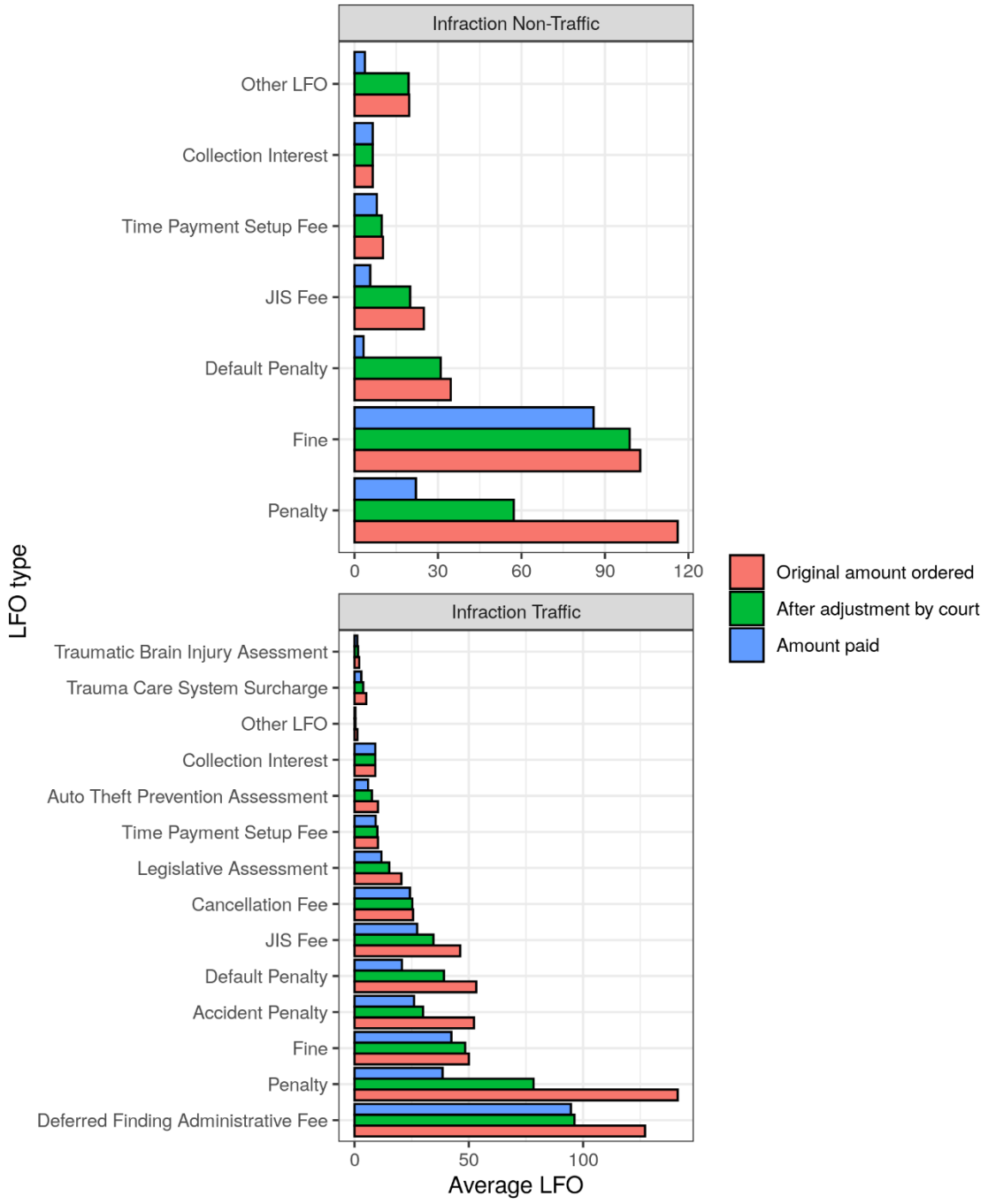


Figure 7 shows the average age of LFO accounts in SMC by case type for cases filed between 2007 and 2017, setting a maximum age of 10 years. Note the very short age for most infraction accounts. The average traffic infraction account is opened and closed within 4.3 months. The average non-traffic infraction account is opened and closed with 6.2 months. Criminal accounts tend to be sentenced to much higher amounts (see Figure 3), and tend to remain open much longer. The average non-traffic criminal account remains open for 1.2 years, but note the long tails on the distribution of case ages; some accounts remain open much longer. The average criminal traffic account remains open for about 2 years, and the average DUI account remains open for about 4.6 years. Note that a non-trivial number of criminal accounts remained open and not fully paid for a full 10 years.

Figure 7. Age of LFO accounts at closing date by case type in Seattle Municipal Court, 2007 - 2017

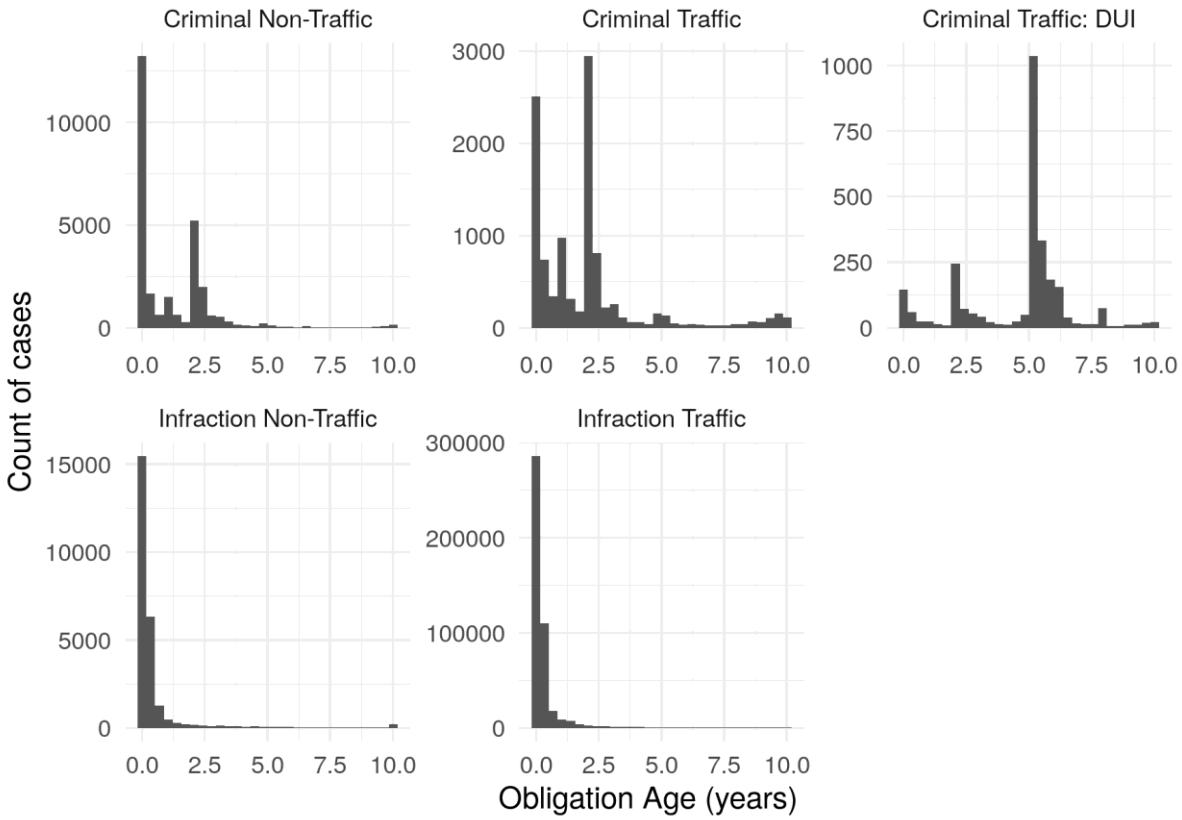


Figure 8. Expected length of LFO account time to close by case type, 2007 - 2017

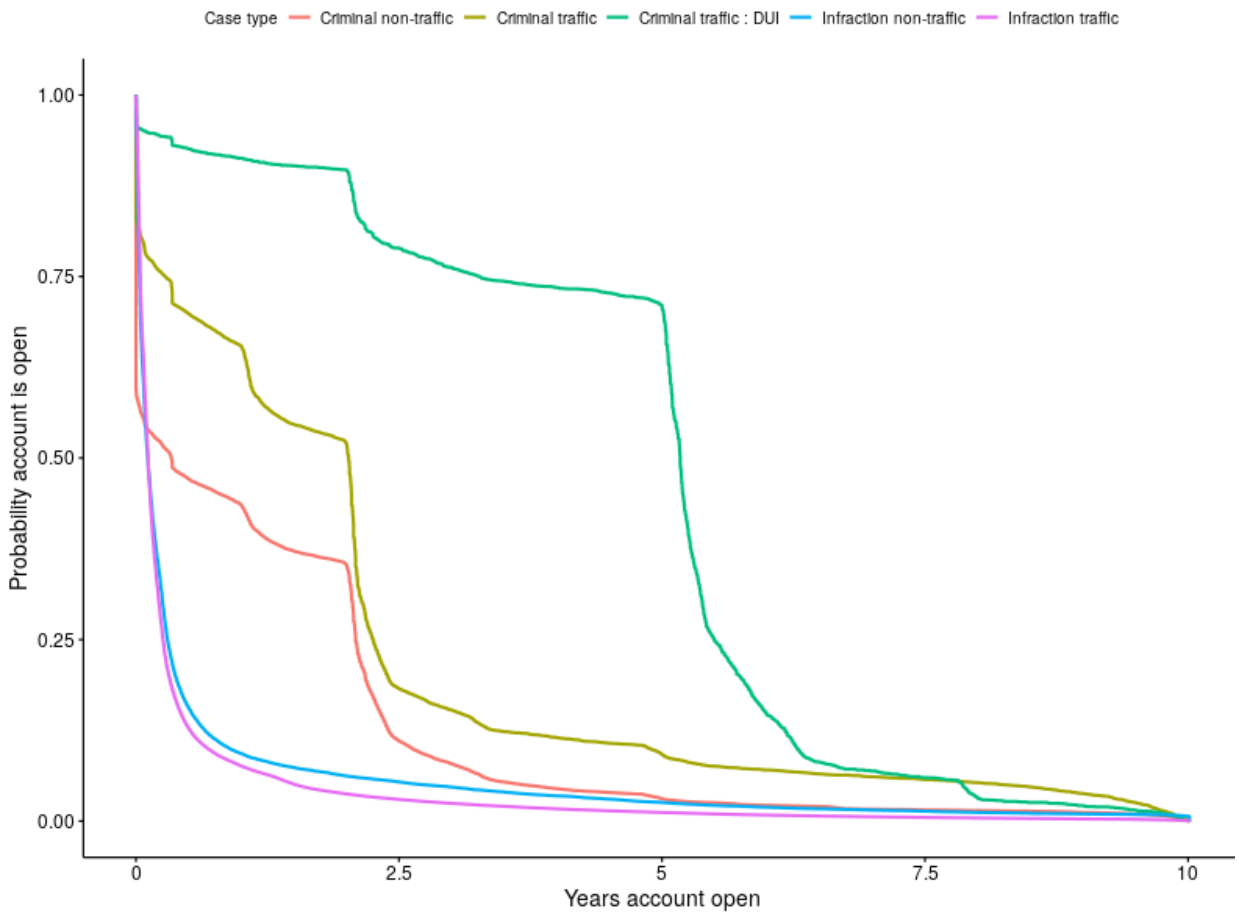


Figure 8 shows the results of a survival analysis of LFO account closure. Survival analysis is a statistical method that allows estimates the time to an event across different kinds of cases, including for cases that have not yet experienced the event (censoring). In this case, we estimate how long, on average, different kinds of LFO accounts remain open by building a statistical model that estimates the average time it takes until a case is closed. Below we illustrate the probability of an account remaining open as a function of the account's age and the case type. DUI cases tend to survive the longest. Over this period, about 75 percent of DUI LFO accounts are expected to remain open and not fully paid after five years. Other kinds of accounts tend to close much more quickly. Few infraction LFO accounts remain open after one year, and the majority of non-DUI criminal cases are closed within 2.5 years. Non-traffic criminal cases tend to close more quickly than criminal traffic cases.

2. Relationships between SMC LFOs and more serious criminal justice system contact

In this section we are interested in understanding the criminal justice consequences for people who have unpaid court debt. We examine the relationship between court debt sentenced in SMC with a subsequent conviction in Washington State Superior court. We conduct a longitudinal analysis that explores whether court debt predicts future incarceration. That is, what is the likelihood that someone will be incarcerated if they carry LFO debt. Note that these are not causal estimates, and do not identify the effect of SMC fines and fees on future incarceration. Instead, our estimates describe associations between debt and future incarceration outcomes. The figures below should be interpreted as the expected conditional probability of future incarceration after SMC LFOs for each group. However, these estimates do not capture the *independent* impact of SMC LFOs on future incarceration because unmeasured variables likely confound the relationship between court debt and future criminal justice outcomes. However, these models can accurately predict the proportion of people in each category (e.g. White, with unpaid LFO) who are likely to experience a particular outcome after receiving an LFO through SMC.

In these models, we use data from the Washington Administrative Office of the Courts (AOC) to identify the first time a person was sentenced to jail or prison by a Washington Superior Court. We then match these first-time incarceration records to SMC LFO records based on a person's name and date of birth. Note that because some names or dates of birth likely do not exactly match across AOC and SMC data, these probabilities / proportions should be taken as conservative estimates. Also, note that these models predict first incarceration sentenced in Superior Court in Washington. It is possible that LFO sentencing relates to pre-trial incarceration or incarceration sentenced in municipal or district courts, to incarceration for technical violations of conditions of release or deferred adjudication, or for recidivism and desistance. These models do not capture these outcomes.

Figure 9 displays the results of a logistic regression model of the probability of being sentenced to jail or prison in a Washington Superior court following sentencing to LFO debt in SMC. We display predicted probabilities of incarceration from a regression model that assumes the LFO was sentenced in 2010, that the amount sentenced was $175, and that the person had not been previously been sentenced to incarceration in a Washington Superior Court. We estimate these probabilities separately for men and women, and by race/ethnicity. Note that model inputs include defendant race, gender, case type, total obligations sentenced, whether any payment was recorded, and the year in which the case was filed.

We begin by examining the likelihood of a person receiving a sentence to jail or prison by a Washington State Superior Court judge among the population of people who have been sentenced to SMC LFOs and who have paid them. The bottom panel of Figure 8 shows the probability of being sentenced to incarceration by a superior court following LFO sentencing in SMC when the balance of the sentenced LFO was paid in full by race and sex. For each class of case, Black men and women are significantly more likely than their peers to be sentenced to incarceration following an SMC LFO paid in full. This includes non-criminal infractions.

Figure 9. Proportion sentenced to incarceration in Washington Superior Courts after being sentenced to $175 in SMC LFOs (adjusted) by race, case type, and payment / non-payment, logistic regression expected values.

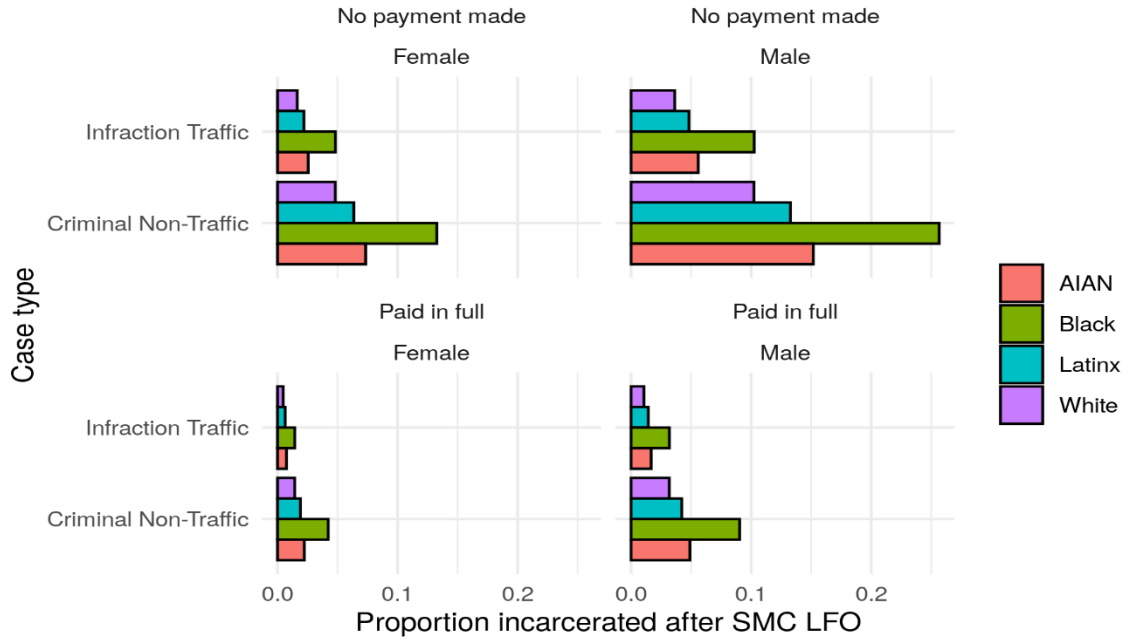


Table 3. Highlights these findings for Black and White men. We estimate that a Black man sentenced to a $175 LFO in SMC for a traffic infraction that has paid their LFOs in full has about a 3 percent probability of being later sentenced to incarceration in a Washington Superior Court, compared to about a 1 percent probability for White men. For criminal non-traffic offenses, Black men have about a 9 percent chance of being incarcerated through a superior court following a paid SMC LFO, compared to a 3 percent chance for White men. We find that a Black man with an unpaid LFO from a criminal non-traffic SMC case will have a 26 percent probability of later incarceration through WA Superior courts. This compares to 10 percent probability for White men. In sum, Black men and women are more likely to be incarcerated following an unpaid SMC LFO than are any other group. American Indians / Alaska Natives are also more likely than White or Latinx people to be incarcerated following an SMC LFO. Our analysis finds a correlation between LFOs sentenced, paid and unpaid, for subsequent incarceration with key racial differences.

Table 3. Percent Likelihood of Subsequent Incarceration Post LFO $175 sentence.

	White Men	Black Men
Traffic Infraction		
Paid in full	1.1%	3.2%
Unpaid	3.6%	10.3%
Criminal Non-Traffic		
Paid in full	3.2%	9.0%
Unpaid	10.2%	25.7%

3. Exploration of racial disparities in traffic and non-traffic infractions

In this section we explore the extent to which there may be racial and ethnic differences in the issuance and sentencing of LFOs through SMC. We also explore how likely Seattle drivers are to receive a driving with a license suspended in the third degree (DWLS 3)[ix] charge after receiving any SMC LFOs, and whether there are any racial and ethnic differences in these probabilities. License suspension is a critical consequence of unpaid LFOs, and prior research suggests that low-income people of color may face a heightened risk of license suspension, leading them to more serious criminal justice system involvement (Harris 2016). In this way, license suspension resulting from unpaid LFOs may be an engine of racial and ethnic inequality.

Figure 10 shows the results of a logistic regression model estimating the probability that a driver will be charged with DWLS3 in SMC after receiving any LFO from SMC. Black drivers are far more likely than others to be charged with DWLS 3 following an SMC LFO. About 2.3 percent of all Black men who receive traffic infraction LFOs in SMC can expect to be charged with DWLS 3, compared to about 0.4 percent of White men. Latinx and American Indian / Alaska Native men charged with traffic infractions are more likely than White drivers to be charged with DWLS 3 following an SMC LFO; about 0.8 percent of Latinx men and 1 percent of AI/AN men, on average, will receive a DWLS3 charge in SMC following a traffic infraction at 2000 – 2017 rates.

Figure 10. Proportion charged with driving with a suspended license (3) after being charged with an SMC LFO, logistic regression expected values

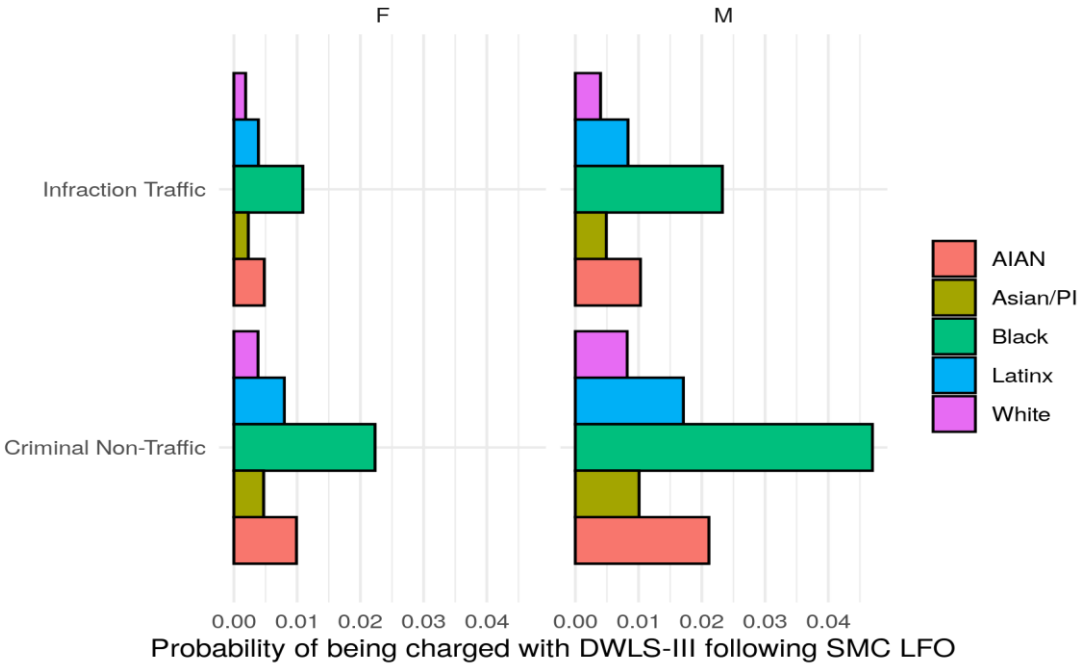
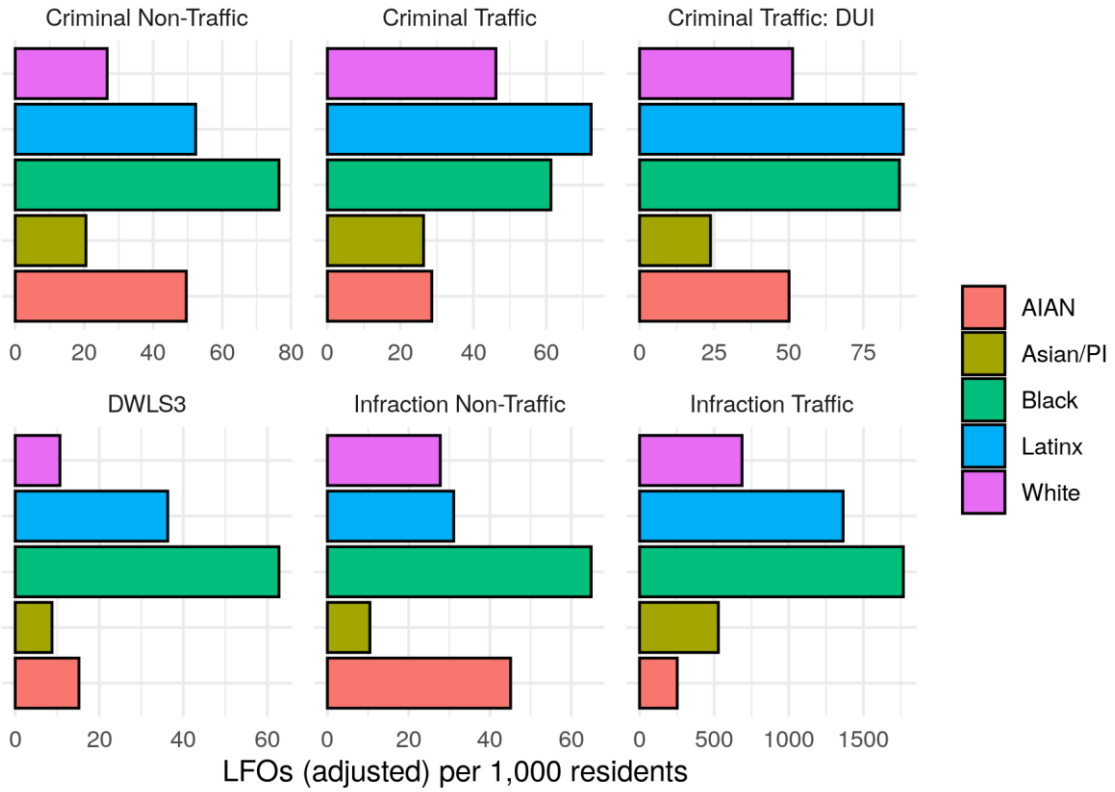


Figure 11. Adjusted SMC LFO debt per 1,000 residents by race/ethnicity and case type, 2017.



Next, we evaluate how LFO debt is distributed across groups in Seattle. **Figure 11** shows the average LFO debt per 1,000 residents of Seattle per year across racial and ethnic groups. Unlike Figure 2, which showed cases per capita, Figure 11 displays the average imposed LFO amount for each category of case, assuming it was evenly distributed across all residents of that group. Black Seattle residents receive more LFO sentences per capita than does any other group in the city for all categories of charges except criminal traffic offenses. Latinx residents receive more LFOs per capita than do Black Seattle residents for criminal traffic offenses.

Between 2000 and 2017, for every 1,000 Black residents in Seattle, SMC issued on average $1767 in traffic infraction LFOs each year, $148 in criminal traffic LFOs, $77 in criminal non-traffic LFOs, and $63 in DWLS3 LFOs. Note that American Indians / Alaska Natives and Latinx people are also disproportionately sentenced to SMC LFOs across many categories of violations.

Figure 12. Ratio of adjusted SMC LFO debt per 1,000 residents by race/ethnicity relative to white, 2014. Dashed line indicates equality.

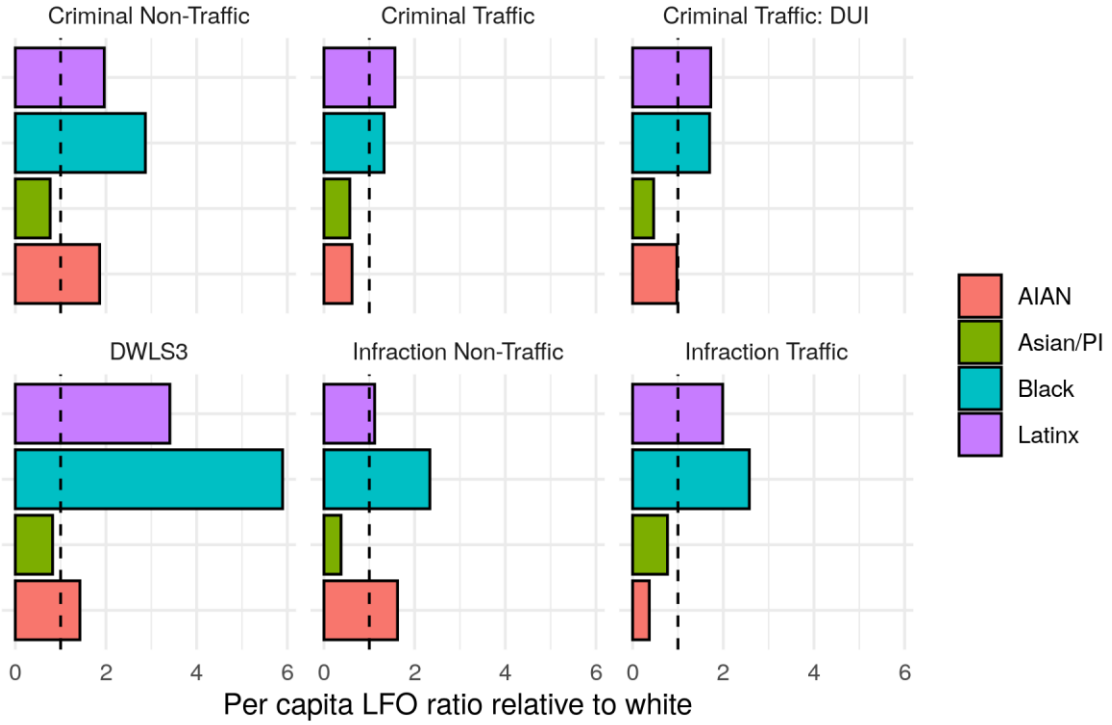


Figure 12 displays per capita sentencing values as ratios of the sentencing per capita for people of color in Seattle relative to the sentencing values White people received. This ratio provides a measure of disproportionality in LFO sentencing relative to population size by race/ethnicity. The dashed line at 1 indicates equity in LFO sentencing for White and non-White groups. Black people in Seattle are sentenced to DWLS3 LFOs at a rate nearly 6 times higher than the rate at which White people in Seattle are sentenced to DWLS3 LFOs. Latinx residents are sentenced to DWLS3 LFOs at a rate 3.4 times higher than the White sentencing rate. Black and Latinx Seattle residents are sentenced to LFO debt at higher rates than White Seattle residents for all categories of violations. American Indian / Alaska Native Seattle residents are sentenced to higher levels of debt than White residents for criminal non-traffic, infraction non-traffic, and DWLS3 than are White residents. There is a high degree of inequality measured as per capita debt load, but relatively low inequality measured as median adjusted court ordered debt. In sum, our exploration of racial disparities in traffic and non-traffic infractions illustrate a high degree of racial/ethnic disproportionality in both the case volume and ability to pay.

4. Comparison of the City of Seattle LFO process with other cities in WA State

Below, we compare SMC LFO sentencing practices and caseloads to other municipal courts across Washington using data from the Washington Administrative Office of the Courts (AOC). Because coding systems for LFO obligation types differ across data systems, and municipal codes vary significantly across the state, we focus our comparison on aggregate LFO measures. Because of these complexities, and differences within courts across judges, it is difficult to directly compare the imposition of particular legal financial obligations. Instead, we focus here on comparing how caseloads, average sentences, and total debt loads have varied across jurisdictions over time. We divide Washington municipalities into those with fewer than 10,000 residents, greater than 10,000 but fewer than 50,000 residents, greater than 50,000 but fewer than 75,000 residents, greater than 75,000 and fewer than 100,000 residents, more than 100,000 but fewer than 250,000 residents, and Seattle. Note that our AOC data only cover 2000 - 2014, while our SMC data cover 2000 - 2017. As such, we truncate the Seattle data to only include the years 2000 - 2014 to maximize comparability.

Figure 13. LFO debt ordered (adjusted) per 1,000 residents in Washington Municipal Courts, by population size of city

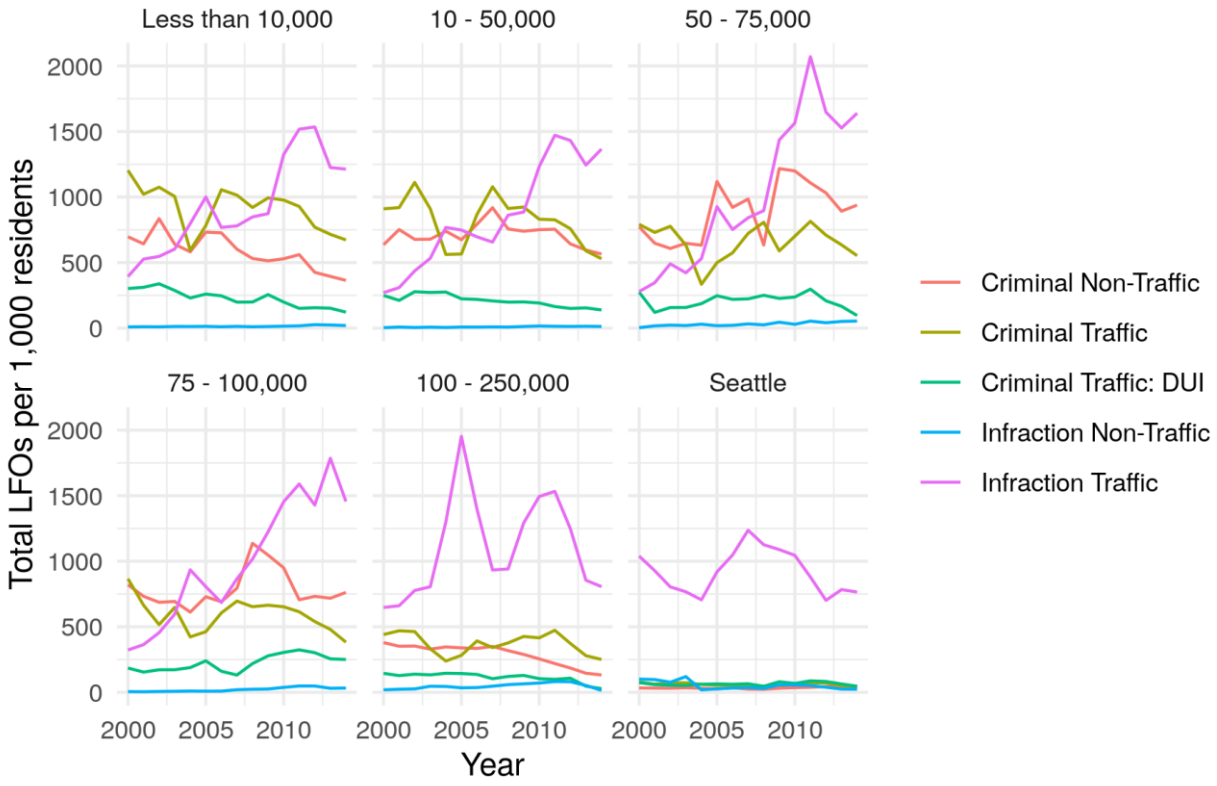


Figure 13 displays the median annual per capita LFO volume across Washington municipal courts. Note that LFO volume per capita is sensitive to case volume, sentenced amount, and population size. In all jurisdictions, non-traffic infractions make up a very small share of overall debt loads. Traffic infractions make up the bulk of debt in large cities, while criminal traffic and non-traffic cases make up a more substantial portion of total debt in mid-sized and smaller cities

and towns. Despite having more cases per capita in recent years than other large Washington cities, the total LFO debt issued by SMC per capita for traffic infractions is similar to the total debt issued by other large city municipal courts in Washington in recent years.

Figure 14. LFO cases per 1,000 persons by case type and size of city population in Washington Municipal Courts, 2014

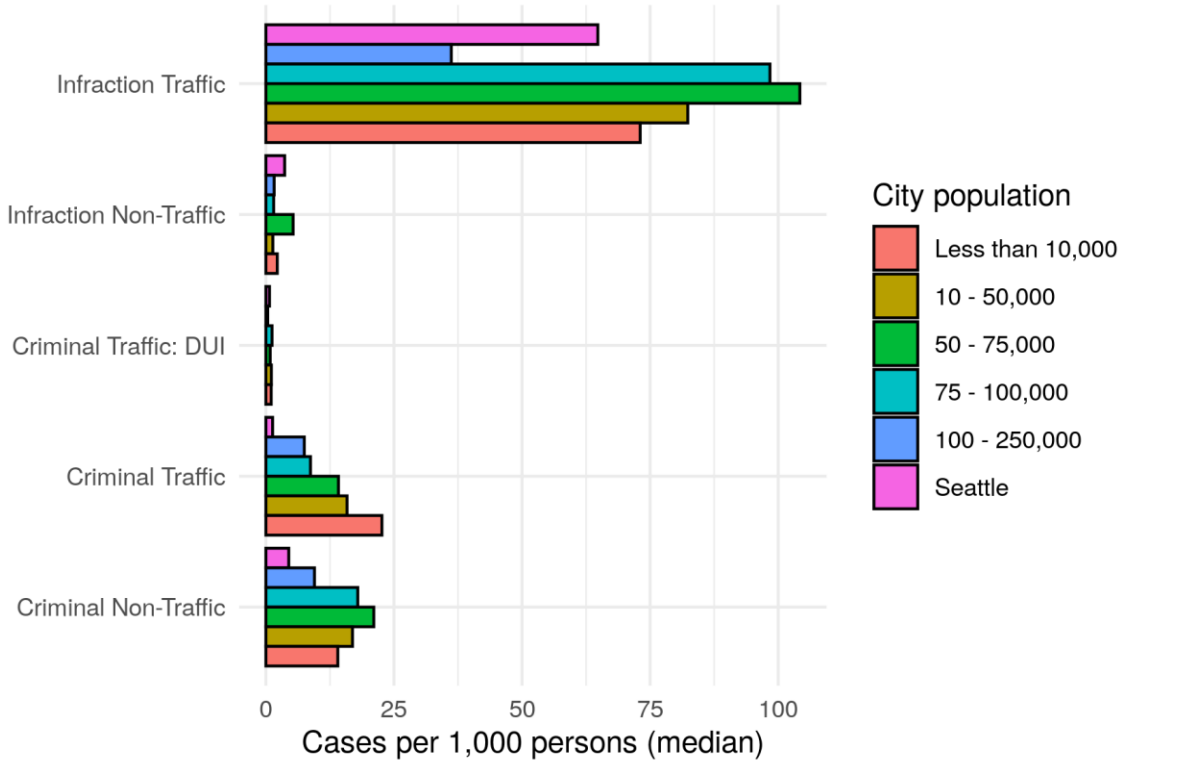
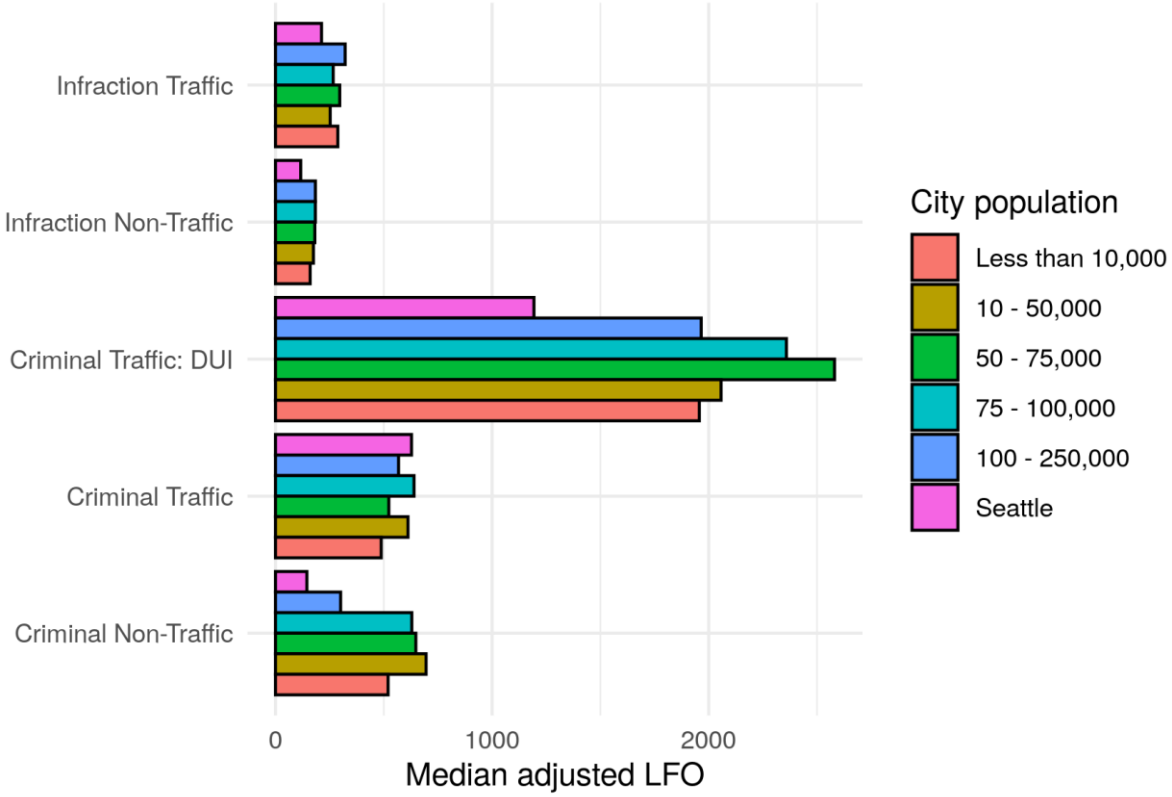


Figure 14 shows the population-adjusted case volume across cities in Washington. In 2014, Seattle's rate of traffic infraction LFO cases was higher than other large cities in Washington, like Tacoma, Spokane, and Everett. However, Seattle issued fewer traffic infractions per capita than did mid-sized cities and small municipalities. Seattle issued more non-traffic infractions per capita than all other classes of cities, with the exception of mid-sized cities (50 - 75,000). DUI rates are similar across all city types. SMC, however, initiates far fewer criminal cases with LFOs than do other cities in Washington. For both traffic and non-traffic cases, SMC's case rate is much lower than other Washington cities.

Figure 15 displays the median adjusted LFO for each class of case in SMC and other Washington courts. SMC issues slightly lower median traffic infraction LFOs than does other municipal courts. The 2014 median in Seattle was $212, compared to a median infraction LFO of $321 in large cities (over 100,000), and $266 in cities between 75 and 100,000 persons. SMC's median DUI LFOs after court adjustment are significantly lower than those in other municipal courts. In SMC, the median adjusted total LFO balance in 2014 was $1193, compared to $1965 in other large cities, and around $2500 in mid-sized cities. For non-DUI criminal traffic cases,

SMC LFO balances are similar to other municipal courts. For non-traffic criminal cases, SMC LFOs are much lower than those commonly imposed in other municipal courts.

Figure 15. Median LFO ordered (adjusted) in Washington Municipal Courts by population size of city, 2017



V. Summary of Findings

Our report examines four areas of interest: 1) the extent and characteristics of LFOs cited and sentenced in SMC, 2) the impact of SMC LFOs on individuals, 3) racial/ethnic differences in a subset of cases (traffic and non-traffic infraction), and 4) comparison of SMC to other municipal courts across Washington State.

In terms of the extent and characteristic of sentenced and outstanding LFO penalties in SMC, the total number of SMC LFO cases trended down from 2000-2017. Traffic infractions comprised the largest percentage of LFO cases in SMC, totaling 83% of all cases. Within all offense categories, people of color were ordered more money per 1,000 residents than were White people. SMC courts adjusted infractions related to LFOs (both traffic and non-traffic) more frequently than LFO cases involving criminal cases (non-traffic, traffic and DUI). In terms of the median LFOs originally sentenced, White people were sentenced/cited on average to the same amount or less than people of color. Black people were paying off LFO debt at lower rates than non-Black people

The issuance of LFOs has a positive correlation with the likelihood of subsequent incarceration. That is, our analysis examining the probability of incarceration with paid and unpaid LFO debt found that Black men and women are more likely to be incarcerated than White men and women post receiving a fine or fee citation or sentence. Black men who have paid off a $175 LFO traffic infraction have a 3.2% subsequently likelihood of incarceration compared to a 1.1% likelihood for White men. Black men with criminal non-traffic LFOs in the amount of $175, and who have paid the costs off, have a probability of incarceration of 9.1% compared with similarly situated White men who have a probability of incarceration of 3.2%. For those who have not paid off the debt they have a dramatically increased likelihood of incarceration, Black men have a probability of 26% and White men 10% of being incarcerated. Both for nonpayment of LFOs and even just the issuing of an LFO that has been paid, increases the likelihood of subsequent incarceration for individuals, but at a higher rate for Black men and women.

Along similar lines, in 2017, people of color overwhelmingly carried more LFO related debt in SMC than White people. This said, it appears that SMC has one of the least punitive sentencing schemas compared to other municipal courts in Washington State. SMC officials ordered the lowest amount of overall LFO sentencings/citations across Washington municipal courts. Seattle Municipal Court has the lowest mean ordered LFOs except within criminal traffic court, which are at par with other cities in the state.

In sum, it is clear that there are negative impacts resulting from LFOs imposed by Seattle Municipal Courts, police and traffic officials. These consequences are disproportionately borne by people of color. The consequences we examined include length of court debt and likelihood of incarceration post imposition of debt. Such consequences can have further triggering effects such as the loss of driver's licenses, garnishment of needed wages to support children and families, the issuing of warrants and further incarceration.

VI. Policy Implications

Despite comparatively imposing LFO debts at lower rates than other cities in Washington, Seattle Municipal Courts still engage in a system of monetary sanctions that leads to disproportionate and negative outcomes for Seattle residents, and in particular, people of color. The intended outcome of future policies should be to ensure that individuals who come into contact with the criminal justice system are not permanently disadvantaged by legal debt.

There are several policy implications that emerge from our analysis. First, we suggest that SMC engage in a broader penological discussion with judges and stakeholders in Washington State about the aim of sentencing and citing people for law violations. What is the aim of sentencing fines and fees to people who violate laws? Is there a way to hold people accountable for violations even when they cannot afford the fines and fees? Are there alternatives to LFO sentences that could possibly improve public safely and to hold people accountable? Alternatives should make sure not to reinforce existing inequalities, for example, some people will be able to pay if they have means, while others will be sentenced to work crews. Thoughtful conversations about court sentencing options that include opportunities for individuals to better themselves through furthering education, drug and alcohol treatment, employment readiness, mental health care and community based service should be considered.

Furthermore, policy makers, practitioners and officials should recognize that the system of monetary sanctions has multiple discretion points, a large number of stakeholders, and a large set of costs. For example, SMC judges must manage the traffic citations that police and parking enforcement officers issue. The bulk of the LFOs cases examined in this study were initiated from such citations. Within this context, SMC judges can only adjust the amounts within existing statutes.

More immediate policy changes could include:

- SMC judges should **continue to assess individuals' abilities to pay** in all circumstances when sentencing LFOs. Judges do appear to be adjusting discretionary fines and fees, where they can, upon reconsideration of sentenced amounts.

- Judges should **continue to waive discretionary costs** when people indicate they have little to no ability to pay.

- Policies at the state and local should **interrogate the necessity for add-on financial penalties** such as interest, time payment set-up fee, JIS fee, default penalties, deferred finding administration fee. These costs may inhibit or distract payments towards the fines and restitution.

- **State policy should decouple non-payment from criminal matters and suspension of driver's licenses.** Our analysis highlights huge racial disproportionality in the conviction of DWLS in the third degree to Black men in Seattle. We suggest state policy eliminate driver's license suspensions that result from nonpayment of citations, fines and fees and in turn lead to DWLS in the third degree convictions.

- **State and local jurisdictions should conduct regular monitoring and analysis of LFO sentencing and collections**. Much of our analysis implies the need for local and state court systems to monitor the impact of LFOs on communities of color. SB 1783, as it currently stands, is silent on the issue of racial disparities. Local and state policy should require courts to monitor the impacts of this legal financial obligation on people of color. No punishment schema should produce disproportionate effects for varying populations. Further analyses should be conducted to examine individual level effects including poverty status and race on outcomes such as length of debt burden and subsequent incarceration. This effort would require improving and ensuring consistency in data collection practices across counties and municipalities.

Our findings are consistent with research that suggests the current practice of imposing LFOs has permanently tethered many who are unable to pay to the criminal justice system for a long period of time.[x] The above policy suggestions recognize that poor individuals and people of color experience the criminal justice system differently in a way that limits their full participation in society. These policy recommendations would help address the disproportionality of the effects of LFOs we found in this study. We suggest justice officials work collaboratively to further public safety and enforce a penalty structure that does not lead to racial and economic inequalities such as long-term debt burdens and increased likelihood of incarceration.

Appendix A. Examination of Seattle Municipal Court Observational Data

In conjunction with the SMC data analysis project, Alexes Harris was asked to review Seattle Municipal Court observational data she has been collecting as part of a larger eight state study funded by *Arnold Ventures*. The aim was to examine the extent to which ability to pay hearings were occurring at the time of LFO sentencing. We have a total of 200 hearing observations in SMC. The RA recorded a set of observational codes on a "court observation" coding sheet. A protocol used across court observations in the eight states of foci. **Table** 1 outlines the characteristics of the court type, offenses observed and characteristics of defendants before the court. In addition, the RA recorded hand written field notes on the types of discussions occurring between judges, attorneys and people brought before the court.

Unfortunately, only eight of the hearings the RA randomly observed involved sentencing hearings. As such, not much can be said about the frequency of whether or not ability to pay hearings were being held by SMC judges. Other hearings the RA observed included review hearings, cases involving bench warrants, competency, continuances, DUI pretrial, DV review, mental health review, pretrial, probation review and probation revocation. I also reviewed the field notes (searched for terms "pay" "ability to pay" and "fine" or "fee") no formal "hearings" or discussion of ability to pay.

Interestingly, I found in the text of the field notes frequent discussions between judges, attorneys and defendants about LFO sentences and other court imposed punishments with costs. Much of the discourse focused on people's inability to make any or regular payments. These discussions involved issues related to payment plans, the court imposed $25 community service fee (frequently waived), the $42 criminal conviction fee and probation costs. Several conversations focused on people's inability to find or make payments for court imposed alcohol or drug assessment and treatment. Frequently, people said they could not pay for this mandated sentence.

Table A.1. Summary of SMC Court Observations, 2017-2018 (N = 200 hearings).

	Number	Percentage
Court Type		
Criminal traffic	73	36
Gross misdemeanor	119	59
Misdemeanor criminal traffic	13	6
Type of offense		
Assault	28	14
criminal trespass	10	4
driving with suspended license	9	4
DUI	7	3.5
Domestic violence	7	3.5
Presence under influence of intoxicants	44	22
Reckless driving	13	6
Sexual exploitation	7	3.5
Theft	28	14
Sex		
Women	52	26
Men	148	74
Race/Ethnicity		
Asian	7	3
Black	57	28
Latinx	24	12
Middle Eastern	4	2
Native American	1	0.5
White	79	39
Unknown	7	3
Was not present	22	11
Custody Status		
In	39	20
Out	161	80

VII. Endnotes

[i] For example see Washington State RCW RCW 9.94A.777 https://www.courts.wa.gov/content/manuals/Superior%20Court%20LFOs.pdf

[ii] Alexes Harris, Heather Evans & Katherine Beckett. *Drawing Blood from Stones: Legal Debt and Social Inequality in the Contemporary U.S.* American Journal Of Sociology 115(6): 1755-99 (2010). In for a Penny: The Rise of America's New Debtors Prison. ACLU (2010). Criminal Justice Debt: A Barrier to Re-entry. (2010). Karin D. Martin, et al., *Monetary Sanctions: Legal Financial Obligations in U.S. Systems of Justice,* 1 Annual Review Of Criminology (2018).; Brittany Friedman & Mary Pattillo, *Statutory Inequality: The Logics of Monetary Sanctions in Sate Law,* 5 RSF: The Russell Sage Foundation Journal Of The Social Sciences (2019). Beth Colgan. *Wealth-Based Penal Disenfranchisement*. 72 Vanderbilt Law Review. (2019).

[iii] Alexes Harris, Heather Evans & Katherine Beckett, *Courtesy Stigma and Monetary Sanctions: Toward a Socio-Cultural Theory of Punishment*. American Sociological Review 76(2): 1-31(2011). Alexes Harris, *A Pound of Flesh: Monetary Sanctions as a Punishment for the Poor*. (2016). Alex Piquero and Wesley Jennings. *Research Note: Justice System-Imposed Financial Penalties Increase the Likelihood of Recidivism in a Sample of Adolescent Offenders.* Youth Violence & Juvenile Justice 15(3):1-16. (2017). Leslie Paik & Chiara Packard. *Impact of Juvenile Justice Fines and Fees on Family Life: Case Study in Dane County, WI.* Philadelphia, PA: Juvenile Law Center. (2019).

[iv] Harris et. al, (2010). Mary Fainsod Katzenstein & Maureen R. Waller. *Axing the Poor: Incarceration, Poverty Governance, and the Seizure of Family Resources.* 12 Perspectives On Politics (2015). April D. Fernandes, et al., *Monetary Sanctions: A Review of Revenue Generation, Legal Challenges, and Reform,* 15 Annual Review Of Law And Social Sciences (2019). Alexes Harris, Tyler Smith and Emmi Obara. *Justice "Cost Points:" Examination of Privatization within Public Systems of Justice.* Criminology & Public Policy (2019). Joshua Page, Victoria Piehowski, and Joe Soss. *A Debt of Care: Commercial Bail and the Gendered Logic of Criminal Justice Predation.* RSF: The Russell Sage Foundation Journal Of The Social Sciences 5(1): 150–72. DOI: 10.7758/RSF.2019.5.1.07 (2019)

[v] https://apps.leg.wa.gov/rcw/default.aspx?cite=9.94A.760

[vi] Initially we were tasked with examining the frequency and outcomes for community service conversions, however there was no way to identify or track such cases. A suggestion for future court data collection efforts would be to create a data element that captures when a judge converts individuals conversation of LFO dollars to community service hours. Given the data set we used we are just not able to determine such instances.

[vii] http://www.courts.wa.gov/jislink/?fa=jislink.jis

[viii] Imai, K., & Khanna, K. (2016). *Improving Ecological Inference by Predicting Individual Ethnicity from Voter Registration Records. Political Analysis*, 24(2), 263-272. doi:10.1093/pan/mpw001

[ix] "Driving While License Invalidated" RCW 46.20.342. https://apps.leg.wa.gov/rcw/default.aspx?cite=46.20.342

[x] Harris, Alexes. 2016. *A Pound of Flesh: Monetary Sanctions as a Punishment for the Poor*. Russell Sage, NYC.

AN ANALYSIS OF COURT IMPOSED MONETARY SANCTIONS IN SEATTLE MUNICIPAL COURTS, 2000-2017

Frank Edwards, Assistant Professor, School of Criminal Justice

Rutgers University

Alexes Harris, Professor, Dept. of Sociology

University of Washington

RESEARCH QUESTIONS:

1. Extent and characteristics of unpaid debt
2. Impact of SMC fines and fees on people who cannot afford them
3. Exploration of racial disparities in traffic and non-traffic infractions
4. Comparison of the City of Seattle LFO process with other cities in WA State

DEFINITION, DATA AND ANALYSIS

- Monetary Sanctions: LFO treated as inclusive of all financial debts imposed by a court because of a criminal charge or infraction
  - Includes here traffic citation, court sentenced fines and fees

- Data: Cited or convicted cases 2000-2017 from SMC via the JIS
- Analysis: Frank Edwards conducted statistical analyses using the R statistical programming language
  - Comparisons to other jurisdictions use data from WA AOC of LFO sentencing in WA Municipal courts between 2000-2014

CHARACTERISTICS OF SMC DEBT

MEDIAN ANNUAL TOTAL SMC MONETARY SANCTIONS BY CASE TYPE: 2000 – 2017, INFLATION ADJUSTED

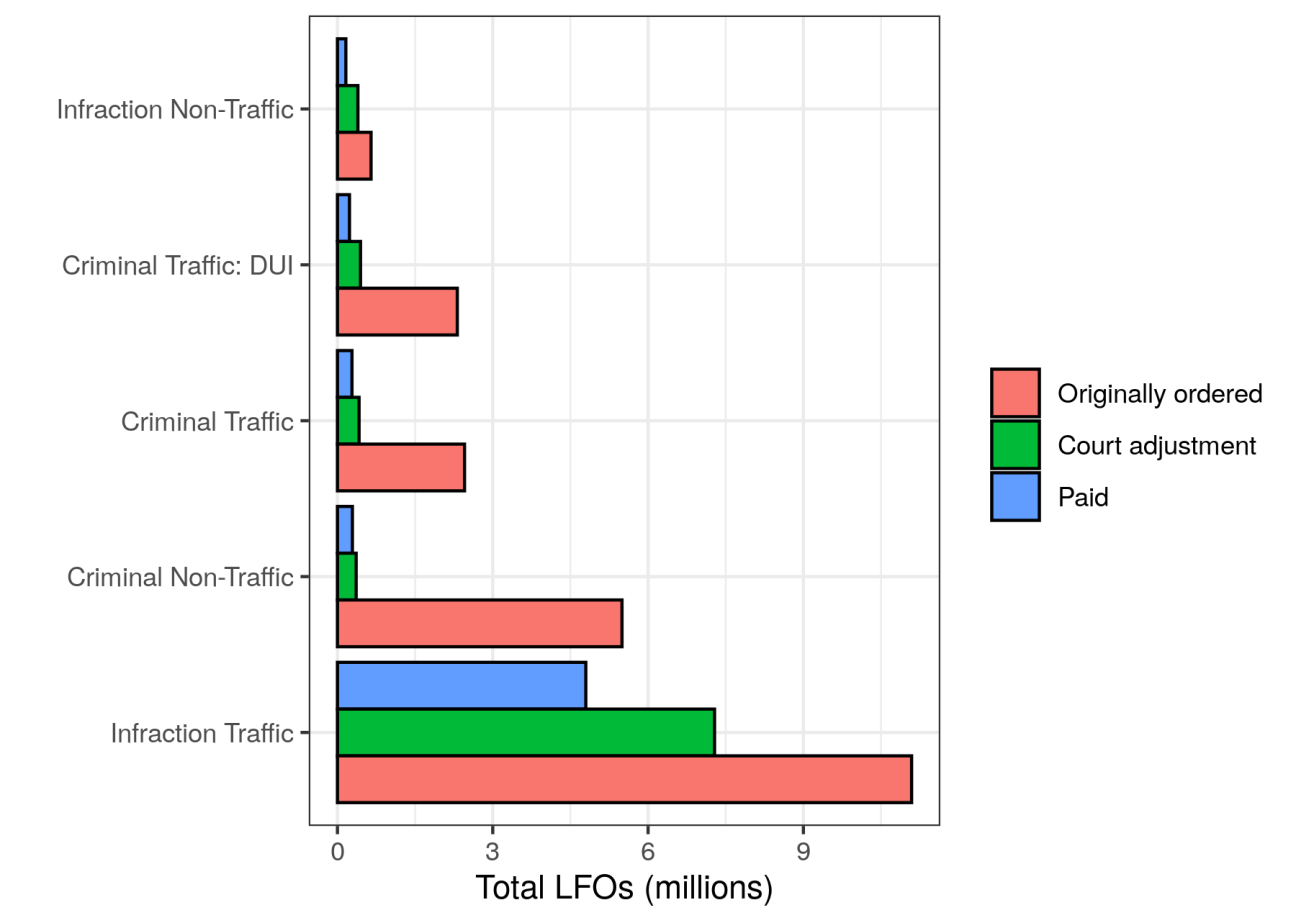
Case type	Originally ordered	After court adjustment	% Adjusted from Original	Paid	% Paid from Adjusted
Infraction Traffic	$ 24,467,354	$ 9,471,204	39%	$ 8,080,052	85%
Infraction Non-Traffic	$ 824,678	$ 406,969	49%	$ 283,779	70%
Criminal Traffic	$ 3,598,035	$ 579,825	16%	$ 528,681	91%
Criminal Traffic: DUI	$ 4,033,011	$ 642,556	16%	$ 543,827	85%
Criminal Non-Traffic	$ 12,041,164	$ 356,704	3%	$ 304,264	85%

DISTRIBUTION OF CASES WITH MONETARY SANCTIONS IN SMC BY CASE TYPE, 2000-2017 (N = 40,672).

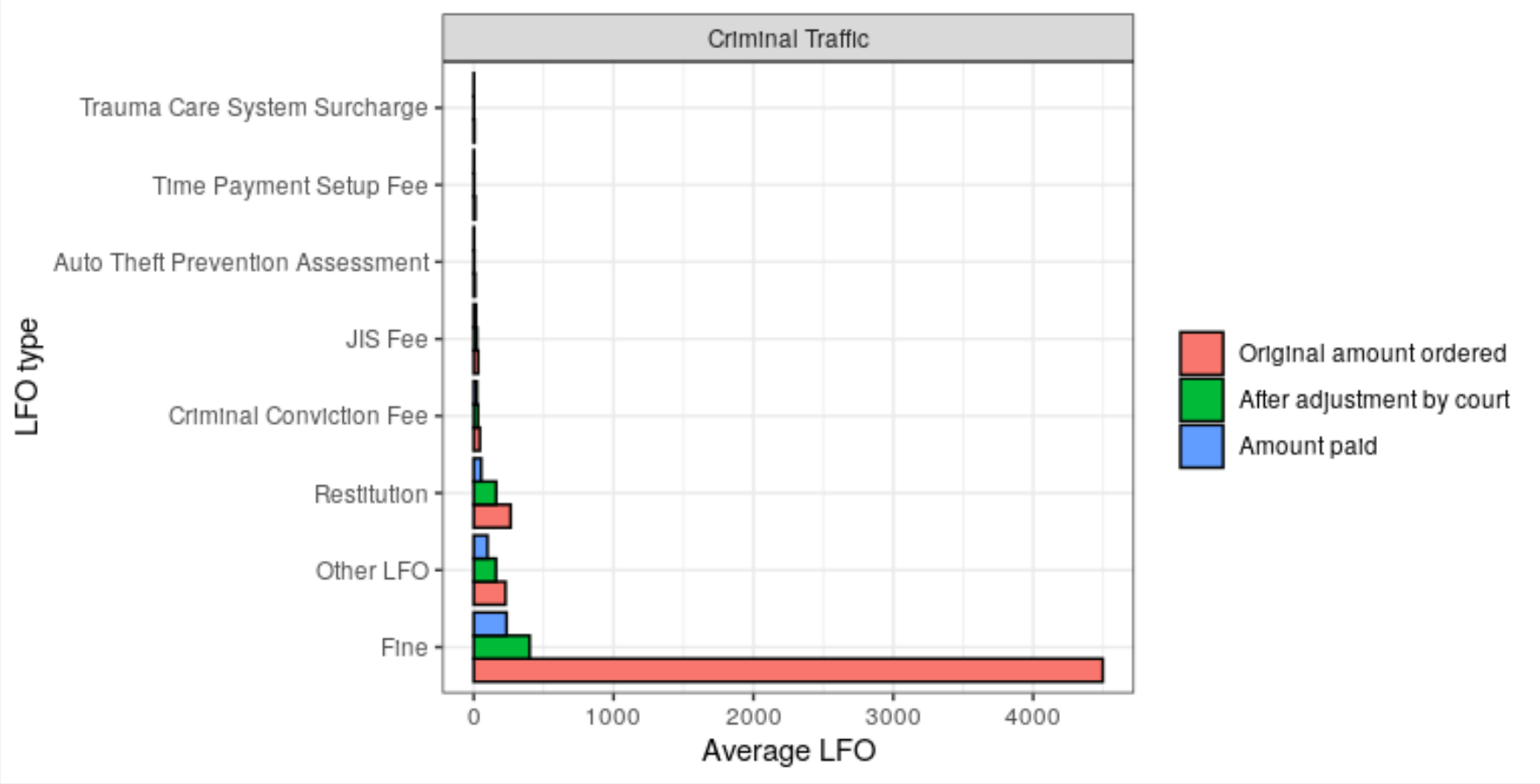
Case Type	% of Total Cases
Traffic Infractions	83%
Non-Traffic Infractions	8%
Non-Traffic Criminal	6%
Criminal Traffic	2%
DUI	1%

SMC CASES WITH MONETARY SANCTIONS, 2000 - 2017

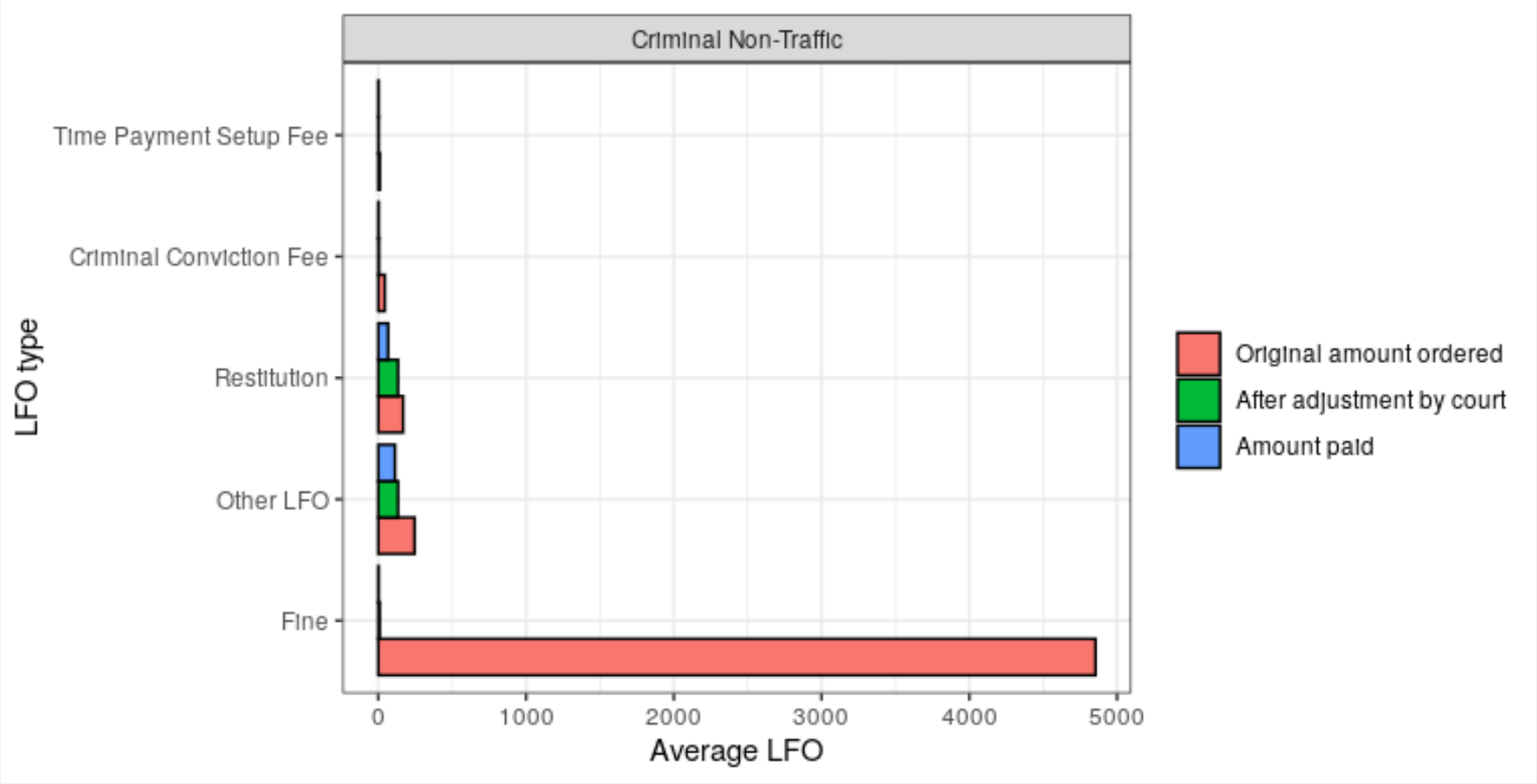
TOTAL SMC DEBT ORIGINALLY ORDERED, AFTER COURT ADJUSTMENT, AND PAID BY CASE TYPE, 2017



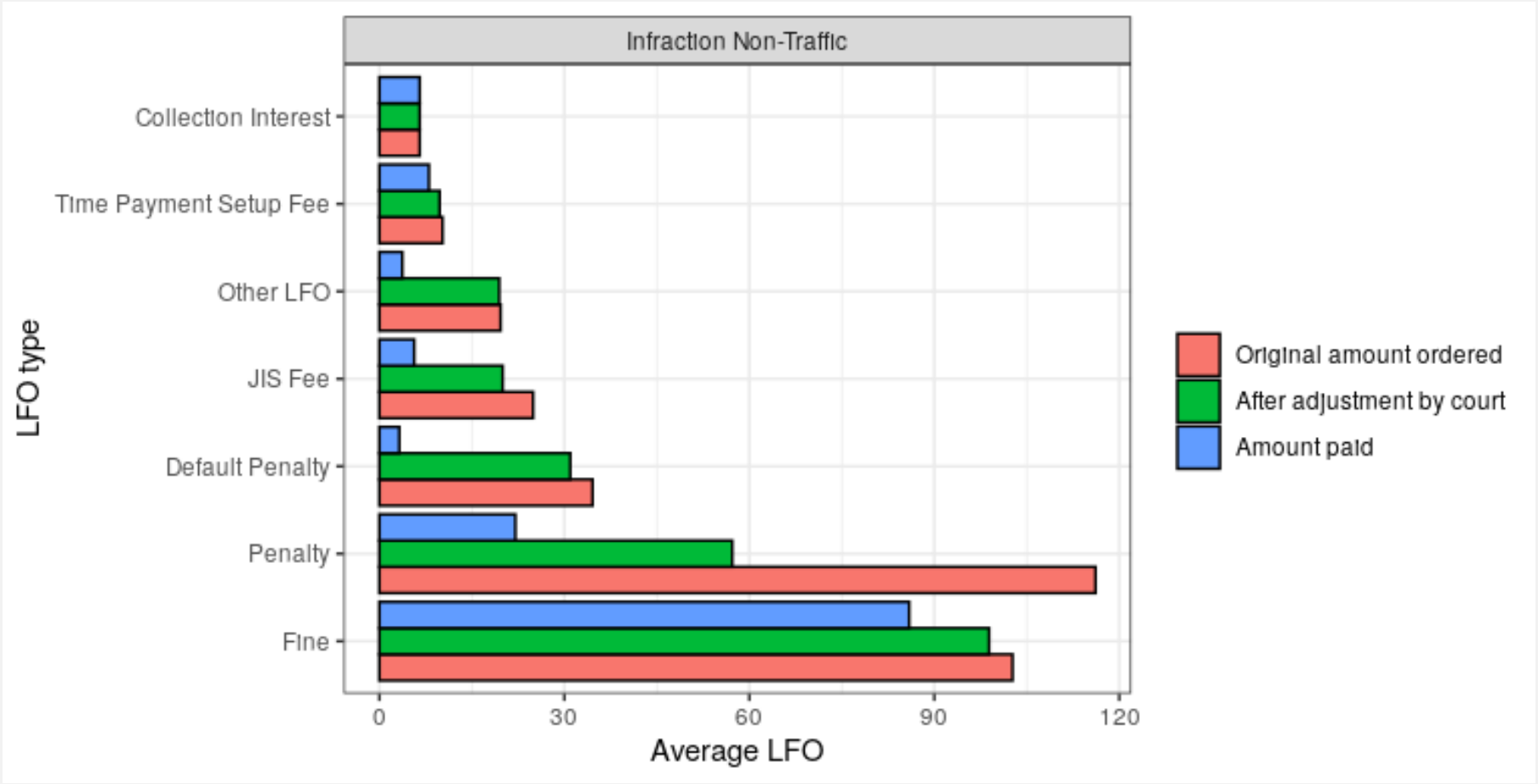
AVERAGE AMOUNTS ORDERED, ADJUSTED, AND PAID: CRIMINAL TRAFFIC



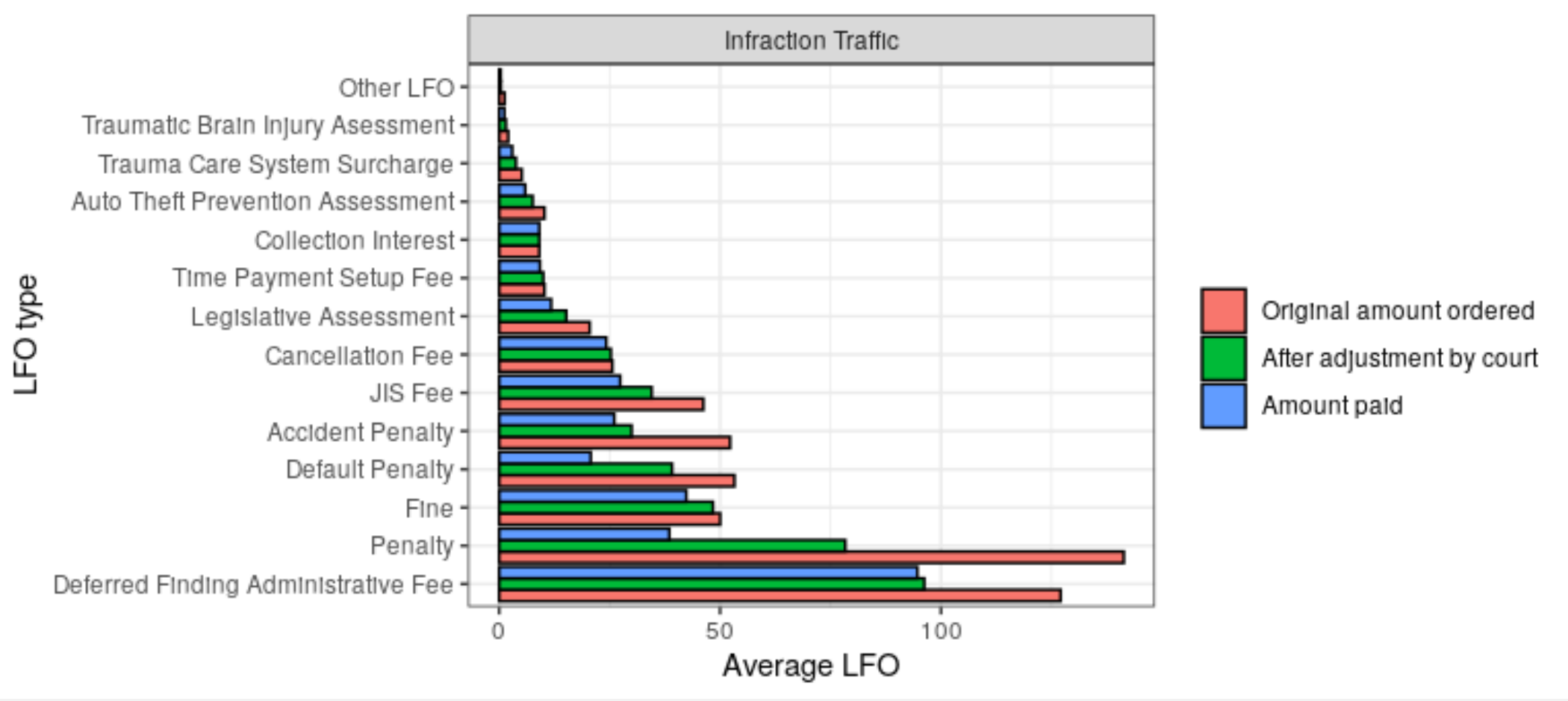
AVERAGE AMOUNTS ORDERED, ADJUSTED, AND PAID: CRIMINAL NON-TRAFFIC



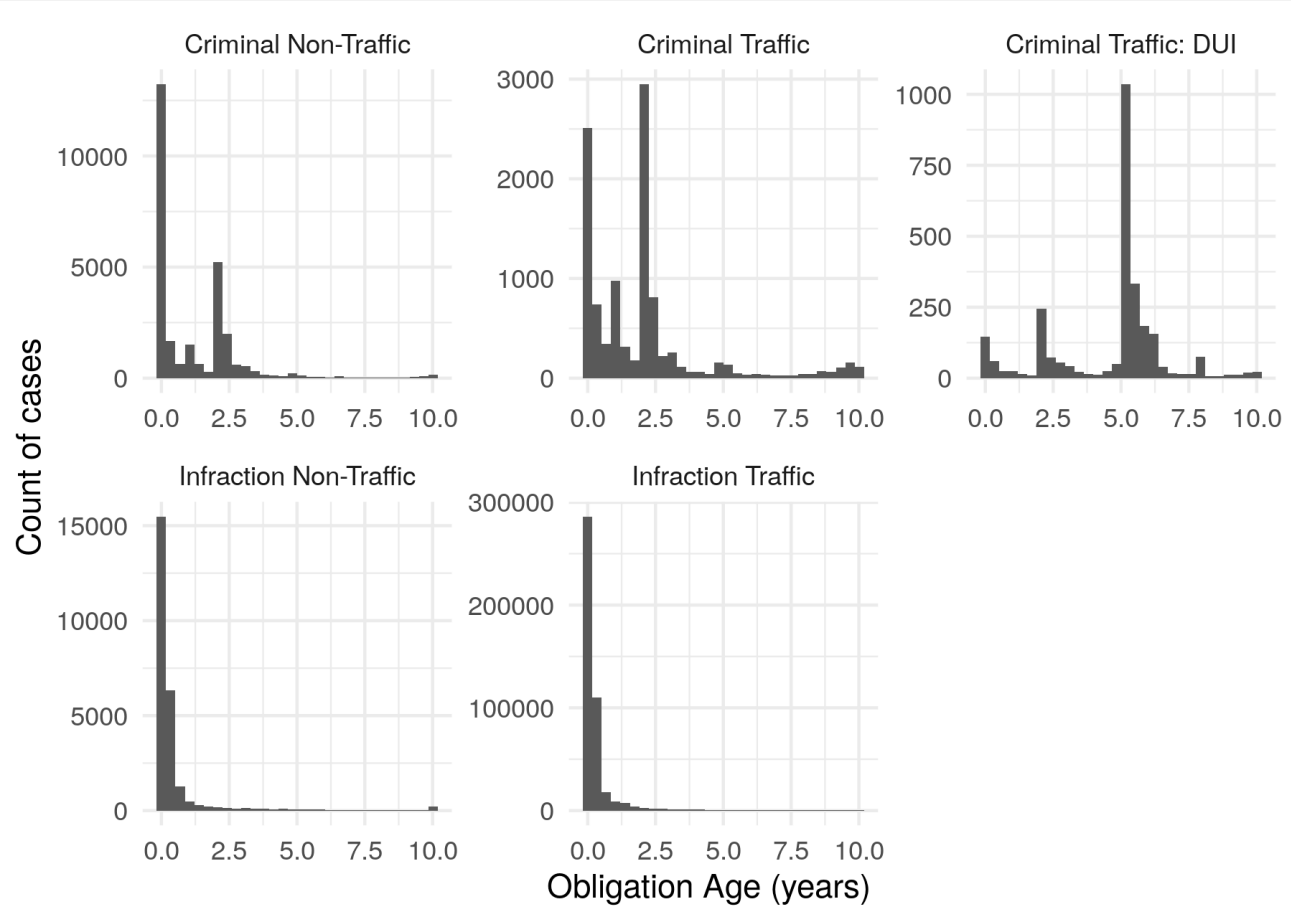
AVERAGE AMOUNTS ORDERED, ADJUSTED, AND PAID: NON-TRAFFIC INFRACTIONS



AVERAGE AMOUNTS ORDERED, ADJUSTED, AND PAID: TRAFFIC INFRACTIONS

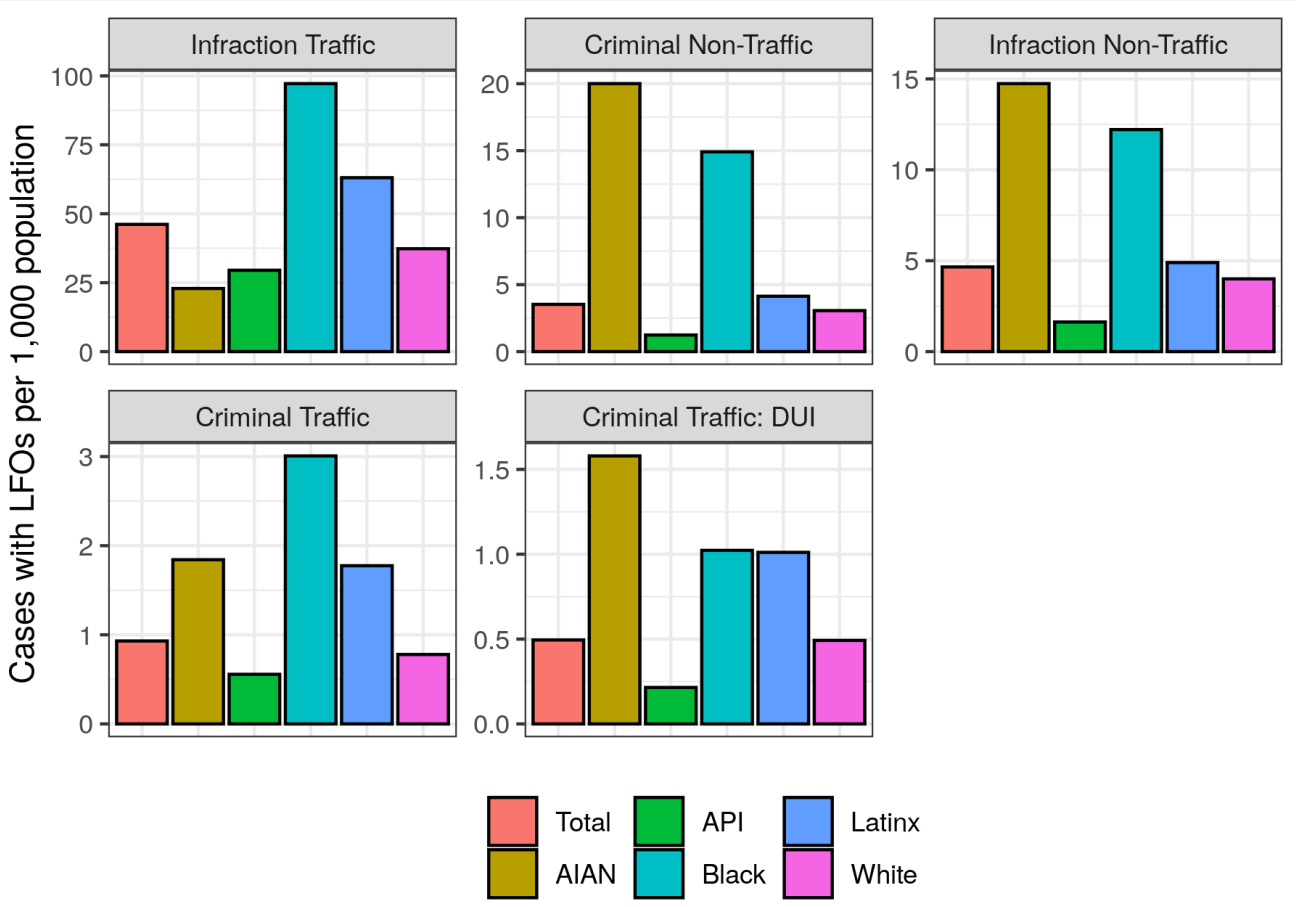


AGE OF ACCOUNTS AT CLOSING DATE BY CASE TYPE, 2007 - 2017

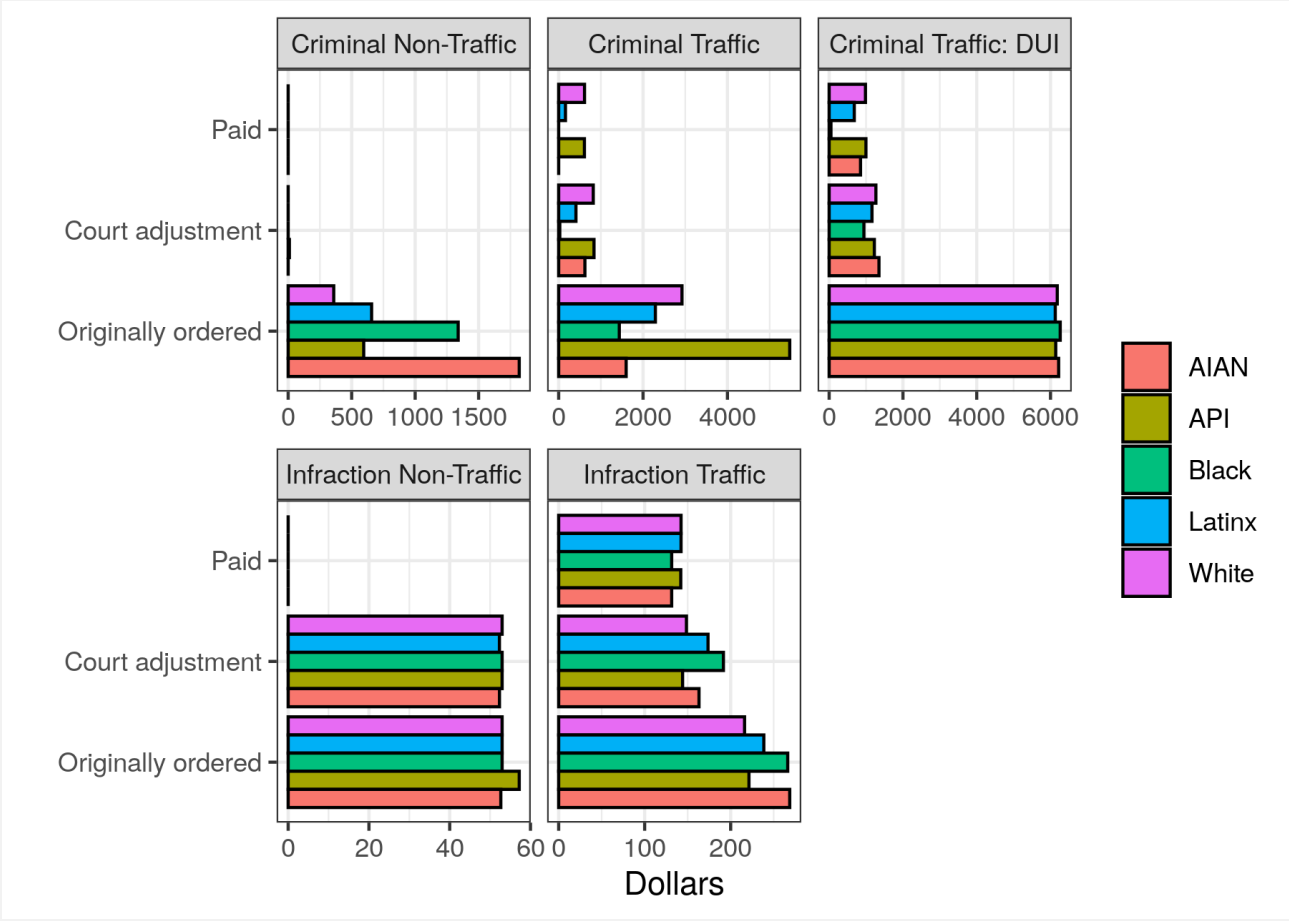


RACE, ETHNICITY, AND SMC DEBT

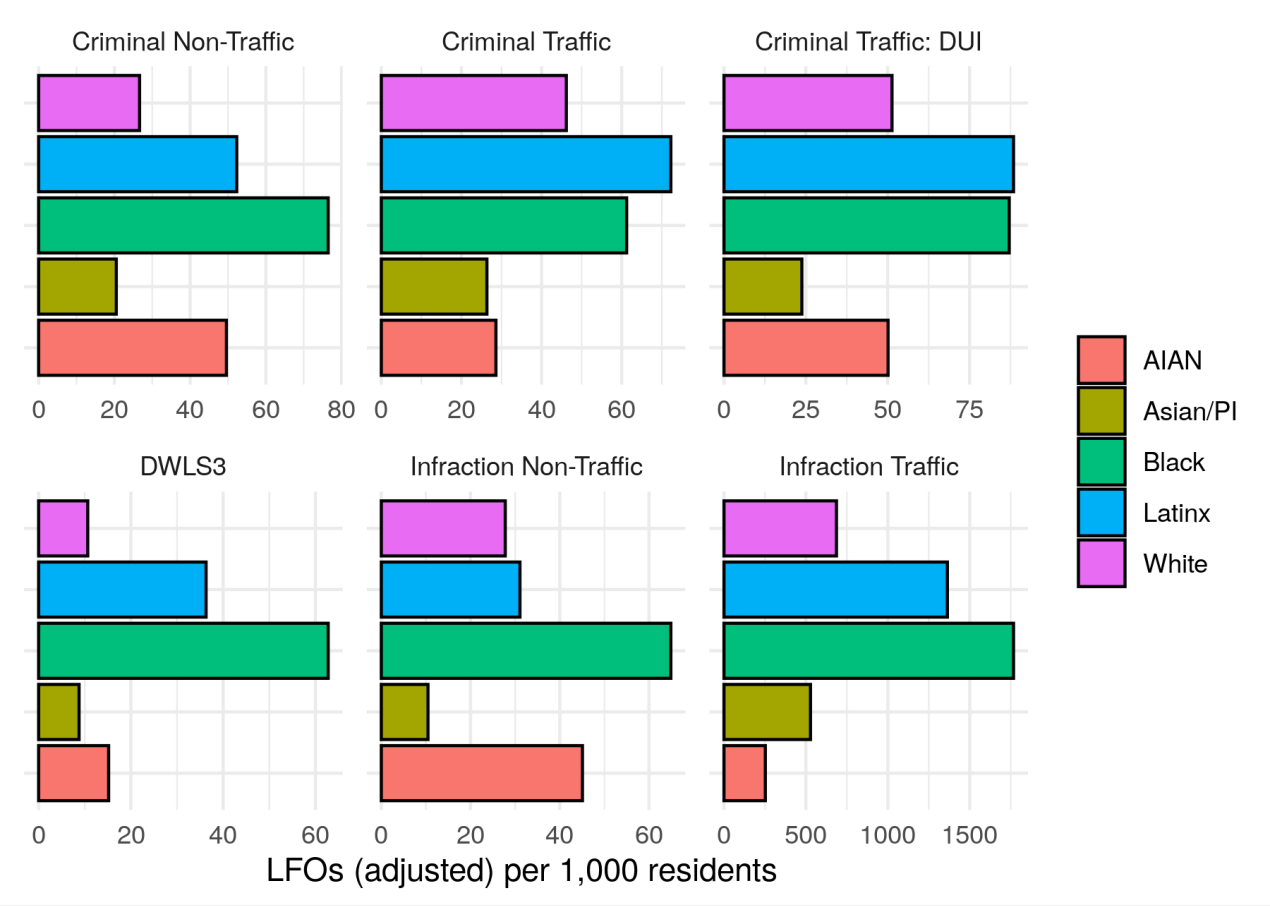
CASES WITH MONETARY SANCTIONS IN SMC PER 1,000 POPULATION BY RACE/ETHNICITY, 2017



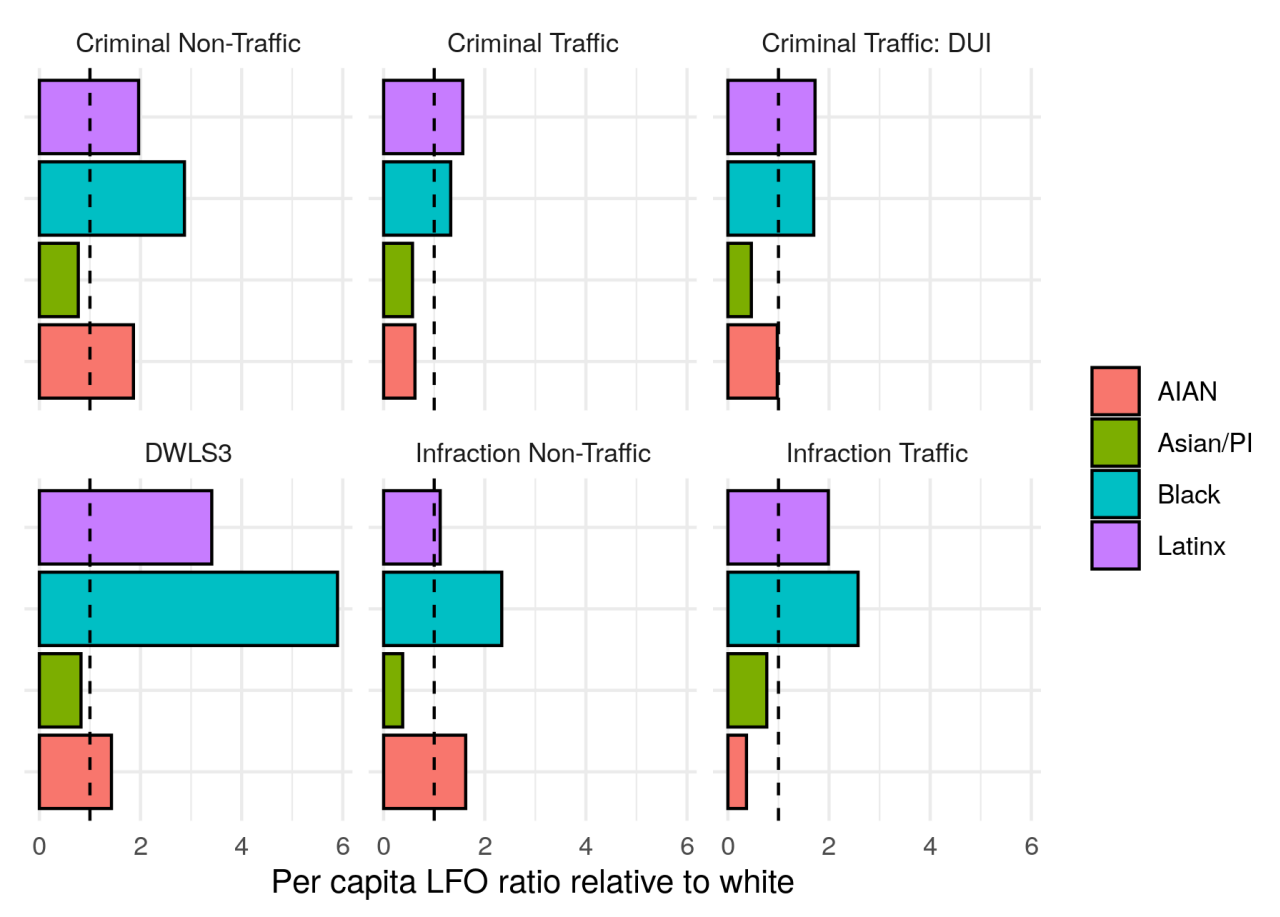
MEDIAN CASE-LEVEL DEBT BY CASE TYPE BY RACE/ETHNICITY, 2015 - 2017



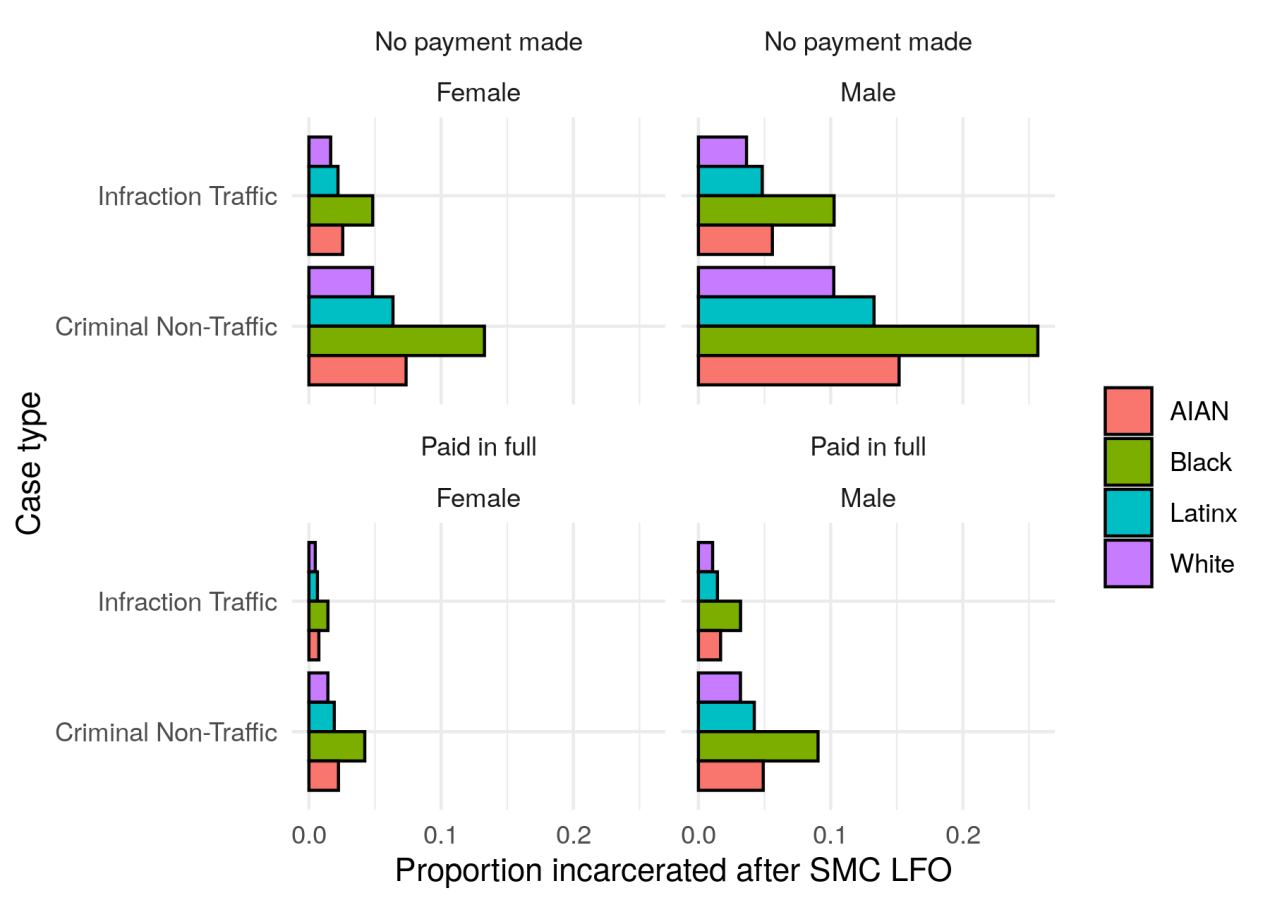
ADJUSTED SMC DEBT PER 1,000 RESIDENTS BY RACE/ETHNICITY AND CASE TYPE, 2017.



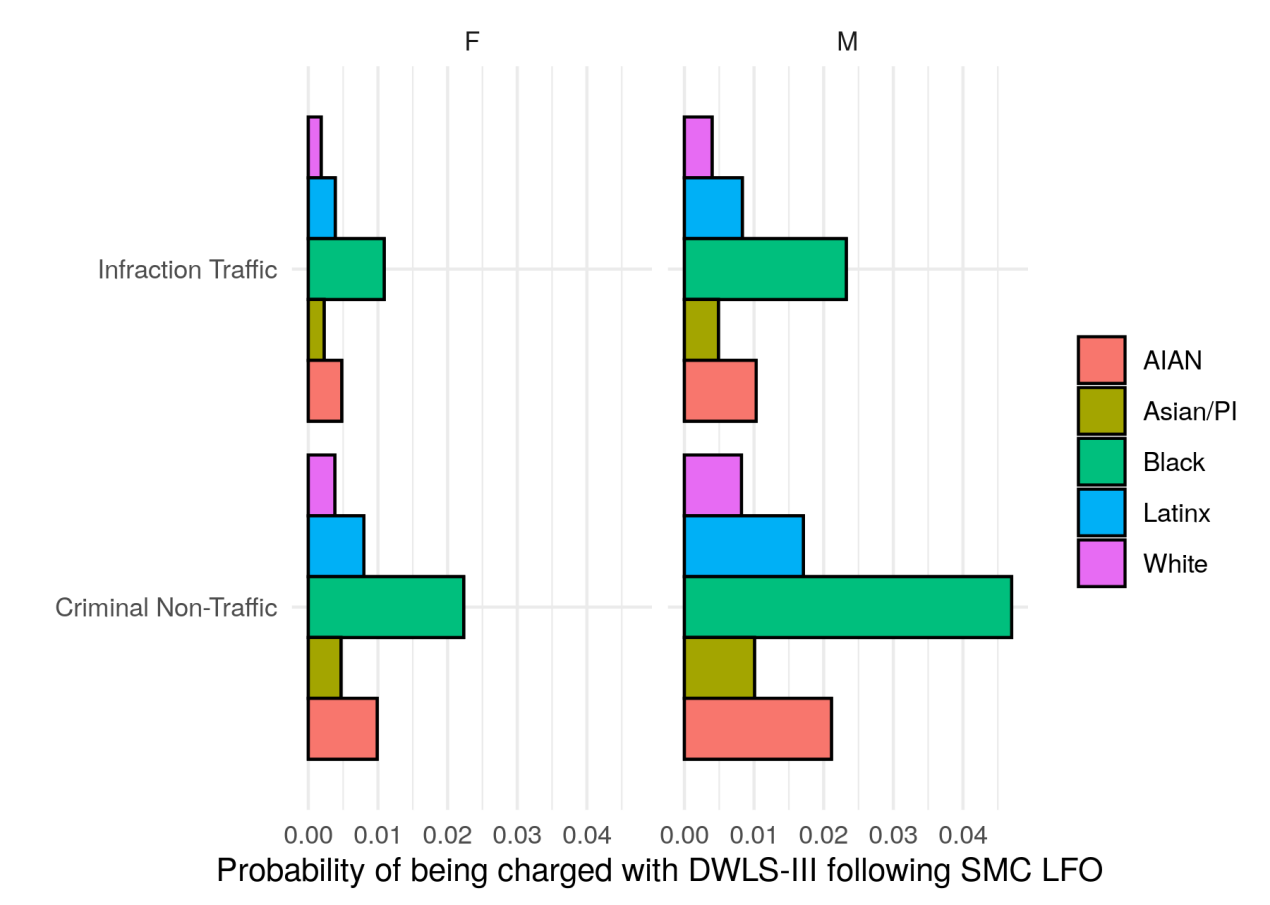
RATIO OF ADJUSTED SMC LFO DEBT PER 1,000 RESIDENTS BY RACE/ETHNICITY RELATIVE TO WHITE, 2014



PROPORTION OF SMC DEBTORS SENTENCED TO INCARCERATION THROUGH WA SUPERIOR COURTS

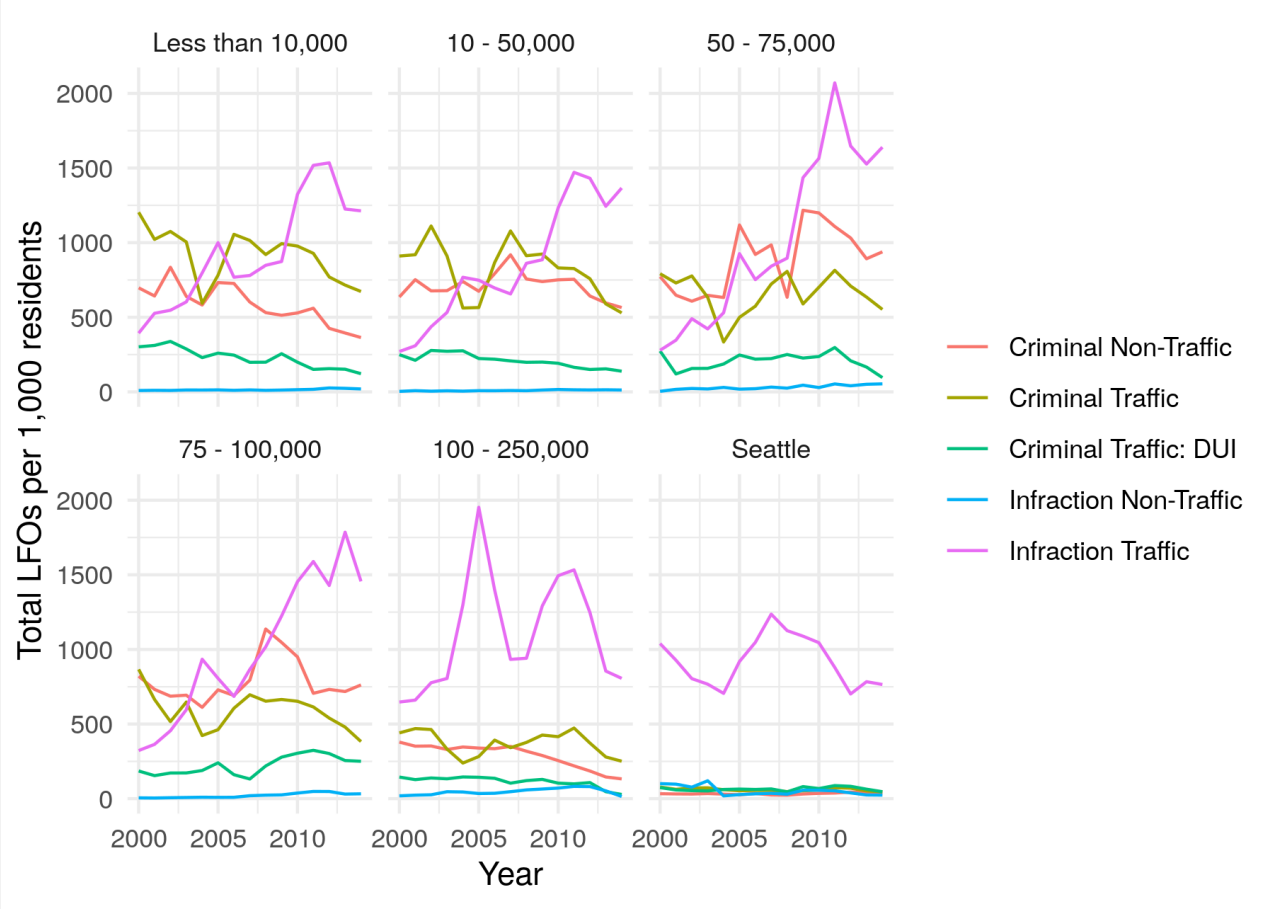


PROPORTION CHARGED WITH DRIVING WITH A SUSPENDED LICENSE (3) AFTER BEING CHARGED WITH AN SMC LFO

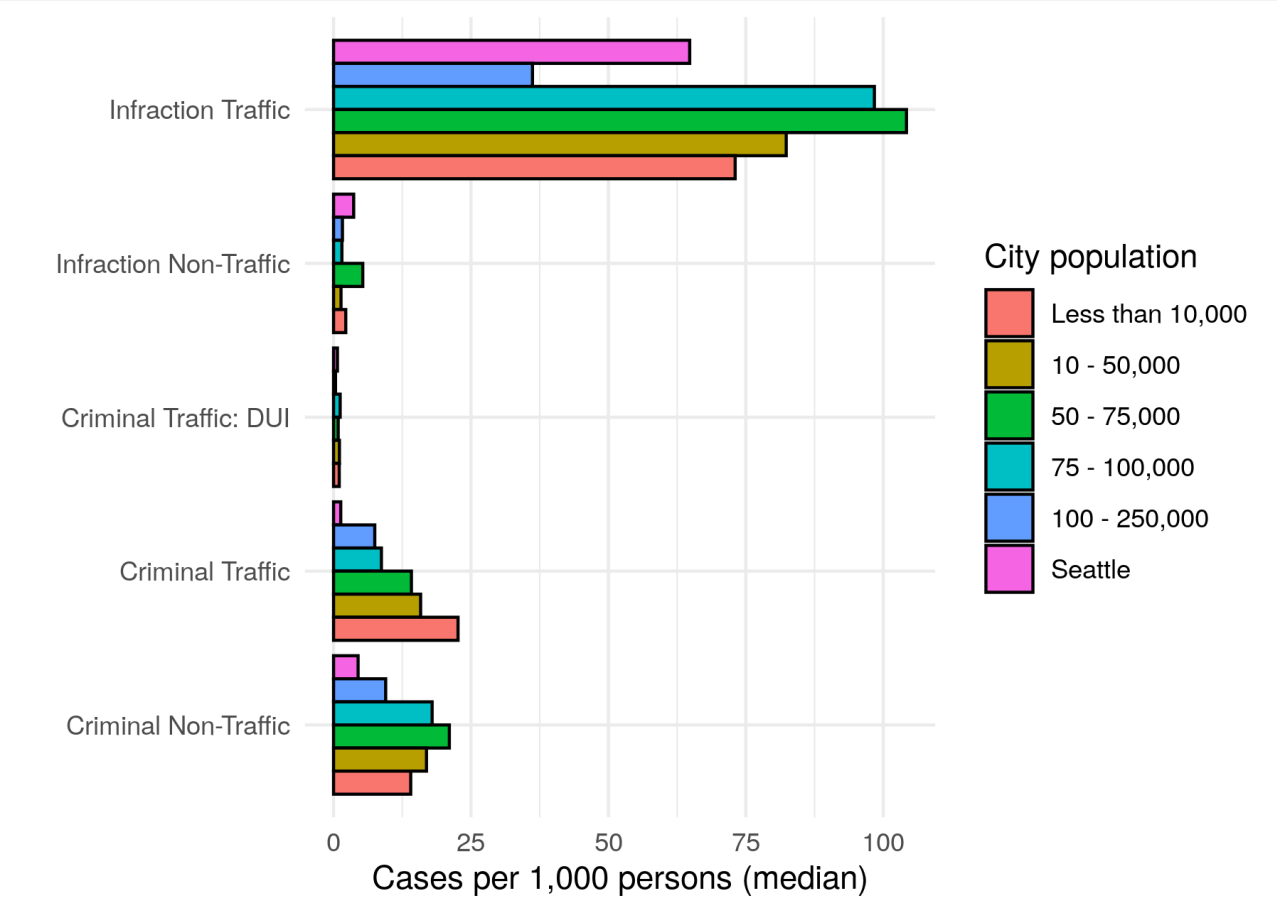


COMPARISON OF SMC DEBT TO OTHER WASHINGTON MUNICIPAL COURTS

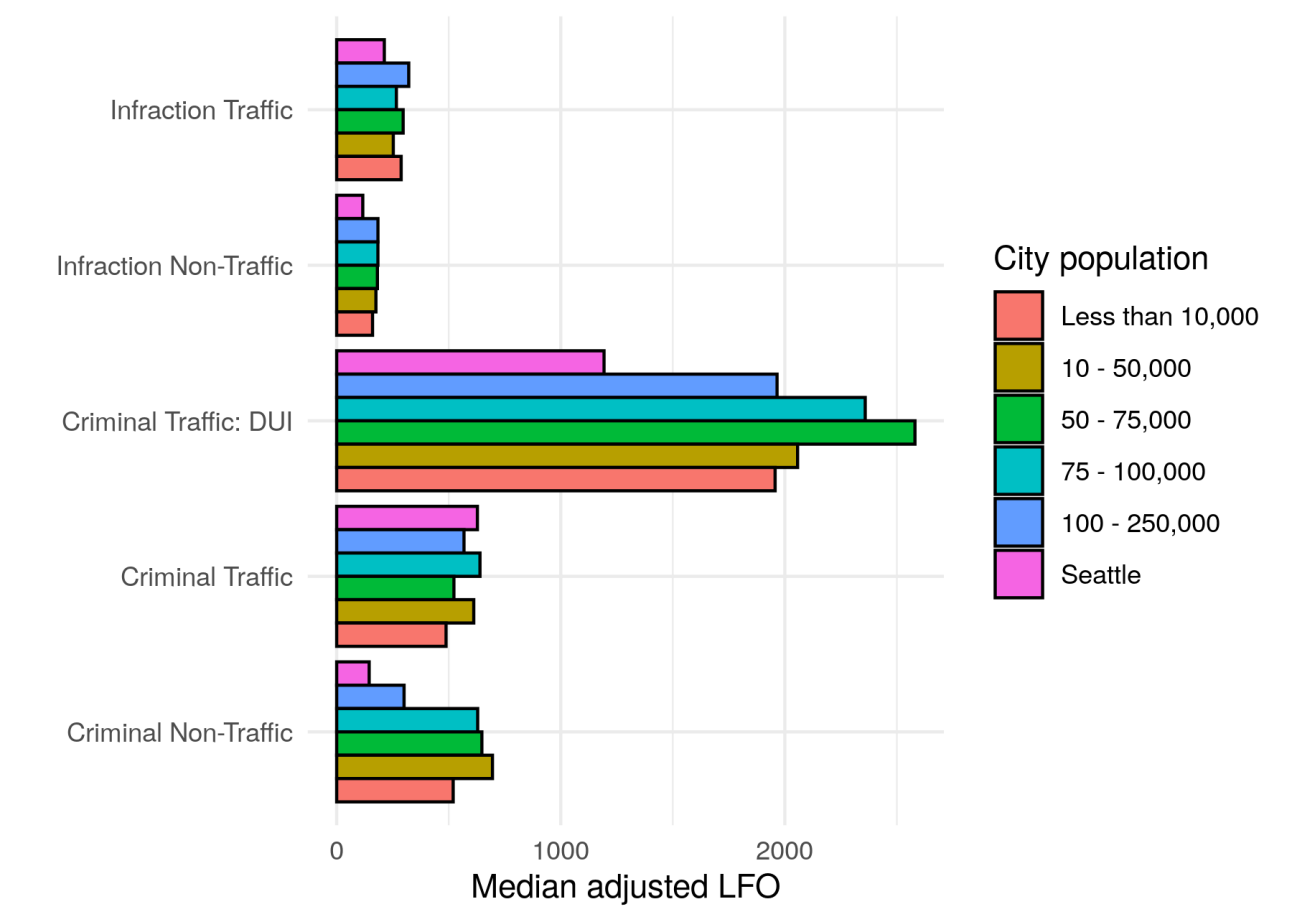
ADJUSTED DEBT PER 1,000 RESIDENTS IN WASHINGTON MUNICIPAL COURTS, BY POPULATION SIZE OF CITY



CASES PER 1,000 PERSONS IN WASHINGTON MUNICIPAL COURTS, 2014



MEDIAN LFO ORDERED (ADJUSTED) IN WASHINGTON MUNICIPAL COURTS BY POPULATION SIZE OF CITY, 2017



SUMMARY OF FINDINGS

1. Remarkable decline in cases filed in SMC between 2000-2017
2. People sentenced criminal traffic cases tended to have LFO accounts open for longer periods of time compared to other types of cases
3. For each class of case, Black men and women are significantly more likely than peers to be sentenced to incarceration through a WA Sup Ct following a PAID SMC LFO

SUMMARY OF FINDINGS

4. For each class of case, Black men and women are significantly more likely than peers to be sentenced to incarceration through a WA Sup Ct following a UNPAID SMC LFO

5. People of color have a higher likelihood than White people to be charged with a DWLS3 following a SMC LFO sentence. Especially pronounced for Black drivers.

POLICY RECOMMENDATIONS

- SMC Judges should continue to assess individuals' abilities to pay in all circumstances
- Judges should continue to waive discretionary costs when people indicate they have little to no ability to pay
- Policies at the state and local should interrogate the necessity for add-on financial penalties such as interest, time payment set-up fee, JIS fee, default penalties, deferred finding admin fee
- State policy should decouple non-payment from criminal matters and suspension of driver's licenses
- State and local jurisdictions should conduct regular monitoring and analysis for LFO sentencing and collections

QUESTIONS

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Legislation Text

File #: Inf 1687, **Version:** 1

Community Service Officer Program Implementation

City of Seattle

Seattle Police Department

M E M O R A N D U M

To: Dan Eder, City Council Central Staff Interim Director
Councilmember Lisa Herbold, Chair, Public Safety and Human Services Committee

From: Adrian Diaz, SPD Interim Chief of Police

Date: September 17, 2020

Subject: SPD Report on CSO Program Implementation (SLI 11-A-1)

Pursuant to Statement of Legislative Intent 11-A-1, adopted with the 2020 Adopted Budget, the Seattle Police Department (SPD) has developed the attached report for review by the Public Safety and Human Services Committee and the Council Central Staff Director.

This report provides a brief background on the reinstatement of the Community Service Officer program and reflects on the status of the implementation and operations of the Community Service Officer (CSO) program, including information on the six new CSOs that were funded in the 2020 Adopted Budget (per the Statement of Legislative Intent).

We look forward to realizing the benefit of many months of work to implement this community-centric program in a way that promotes community collaboration for the purpose of improving public safety and wellness.

cc: Lorena González, Council President
Andrew Lewis, Councilmember
Tammy Morales, Councilmember
Kshama Sawant, Councilmember
Mike Fong, Deputy Mayor
Ben Noble, Budget Director
Angela Socci, Chief Financial Officer
Mark Baird, Chief Operating Officer
Jennifer Devore, City Budget Office
Kara Main-Hester, City Budget Office

The Seattle Police Department's (SPD) Community Service Officer (CSO) program operated for thirty-three years until its discontinuation in 2004 due to budget cuts. Large gaps in service had to be filled, and relationships the CSOs had made in the community were lost. The CSO unit provided exemplary customer service, kindness and respect to the community they served. With the CSO unit being absent from the department for fifteen years, parts of the community connections were lost. The community and SPD felt there was a disconnect and a large gap needed to be filled. Prompted by considerable community interest in the program's revival, SPD requested funding to reinstate the program during 2017-18 Biennial Budget process. The Seattle City Council subsequently set aside funding for CSO program development in 2017 and initial implementation in the second quarter of 2018.

Throughout 2017, SPD worked with Seattle Office for Civil Rights (SOCR) to conduct a racial equity analysis and extensive community engagement. The result was a detailed community engagement report which documents the community input that has informed every aspect of the CSO program development. The community engagement report was taken very seriously and implemented during the hiring process.

1. CSO Program Design Summary

The SPD CSO Unit is staffed by non-commissioned officers who are trained and work as liaison personnel between the community and the Police Department. CSOs do not carry weapons nor enforce criminal laws. Instead, they serve to bridge the service gap on non-criminal calls for service and perform a variety of public safety-related community service and outreach work.

The CSO Unit is a unique community resource that responds to and addresses public safety concerns that do not immediately require a police officer or other agency response. The CSOs provide information and service referrals to individuals who have been contacted by the police. They maintain an excellent working knowledge of available services and resources, which make them ideal "resource connectors." They receive training in police operations, social work, de-escalation, conflict resolution and mediation, crisis intervention, institutional racism and cultural competency, using internal and external training channels. They develop community partnerships to support increased collaboration between SPD and the community for the purpose of leveraging community strengths and identifying alternative strategies to various law enforcement and social issues.

CSOs work assigned areas of the city on foot or in marked CSO vehicles, responding to radio dispatched calls for service. CSOs assist with mediating non-violent disputes (e.g., family, neighborhood and landlord/tenant) and provide follow-up on calls for non-criminal emergency services (e.g., food, housing, transportation and social services). CSOs work closely with dispatchers, police officers, parking enforcement officers, crime prevention personnel and various social service agencies to coordinate police and social services and exchange information.

At full implementation, SPD initially planned to deploy 10 CSOs and 2 CSO Supervisors across two shifts, up to six days a week, Monday through Saturday, excluding Sundays and holidays. The 2020 Adopted Budget funded an additional unit: 5 CSOs and 1 CSO Supervisor. Calls for service are received and

dispatched through the CSO office or by police officer referral through the Communications Center. CSOs are easily identified by a clearly marked "soft" uniform (e.g., collared shirt with "Community Service Officer" in bold letters on back). They will drive vehicles marked with SPD CSO emblems.

The CSOs report to a central command and location to encourage collaboration amongst the unit personnel and ensure consistent training, supervision, and oversight. They are housed in the Community Outreach section, collocated with the department's civilian Crime Prevention Coordinators, who work closely with the community to develop and implement crime prevention strategies and promote community safety through public education, community organizing, and information sharing.

Given the expertise that this group will surely develop on the job, there is an opportunity for CSOs to be deployed on a short-term basis to assist or advise on specific projects. However, the department believes that the scope of the program should not be exclusively limited to a single issue-area (e.g., homeless outreach). As stated above, the CSOs work closely with dispatchers, police officers, parking enforcement officers, crime prevention personnel, and various social service agencies to coordinate police and social services and exchange information – including, but not limited to the Navigation Team and the Crisis Response Unit.

The CSO program has been rolled out over several months and full implementation will happen as the COVID-19 pandemic allows.

2. CSO Program Implementation

SPD has continued to refine the CSO program details in preparation for program implementation. The department has a Police Sergeant who oversees the CSO Unit. Since January, the Sergeant has initiated the development of the job announcement, recruitment and hiring strategies, unit policies, training curricula and onboarding materials. The implementation of the CSO program was strategically planned to ensure that the CSO's would be a diverse group of highly professional individuals that had a great variety of experience that would equitably serve the community. Additional program details are discussed below.

<u>Recruitment / Hiring:</u>

The SPD worked with the Community Police Commission (CPC) to develop a comprehensive outreach strategy to recruit a diverse applicant pool that is representative of the communities the CSO Unit serves. The job announcements were posted from May to September 2019 and widely distributed by the community partners who contributed to SPD/SOCR's Community Engagement Report. SPD received over 1,000 applications for only 18 positions. Following an extremely competitive hiring process, candidates were identified for all positions. Fifteen of the eighteen had been fully on-boarded by March 13, 2020, when a City-wide hiring freeze was implemented. There are three positions whose candidates had not yet completed the background investigation and formal hiring process. The three positions include one CSO Supervisor and two CSOs. These positions will remain vacant due to budget concerns.

The CSOs started work on April 15, 2020 to help meet the communities needs during the COVID 19 pandemic.

Deployment:

CSOs work staggered shifts for evening and weekend coverage. The department plans to deploy two teams Monday through Friday (730-1600) and Tuesday through Saturday (1130-2000). Both teams will be stationed at the Seattle Justice Center (610 5th Ave), a central location conducive to efficient and effective deployment of a city-wide resource, like the CSO Unit. CSOs have assigned tasks and duties throughout their work shift. Their time is split between three categories of work: 1) community engagement and education, 2) resource guidance/connection, and 3) youth services and diversion. CSOs are dispatched by radio through the SPD's Computer Aided Dispatch (CAD) system.

Training:

To ensure CSOs have the skills necessary to provide these services, they will receive comprehensive training in police operations, social issues, de-escalation, conflict resolution and mediation, crisis intervention, institutional racism and cultural relevance. During the training process, CSOs participate in a ride along with patrol to experience what they could encounter in the field. The CSO unit's training was adjusted due to the COVID-19 pandemic. All CSOs have been engaged in internal field training and other trainings that emphasize resources, and resource guidance/connection. The list below represents a sample of known courses available to new CSOs during their onboarding.

- CSO Academy
- Radio Procedures
- Geography
- Bias-Free Policing
- De-escalation
- SMCs / RCWs
- Crisis Intervention
- Domestic Violence
- Traffic Assistance (e.g., Flagging)
- Emergency Vehicle Operation Course (EVOC)
- Computer Aided Dispatch (CAD)
- Landlord Tenant
- Mediation
- Court System Navigation
- Child/Adult Protective Services Navigation
- Motivational Interviewing
- Cultural Relevance
- Indian Child Welfare Act
- Crime Prevention through Environmental Design
- Records Management System (Mark 43)
- Defensive Tactics
- Wellness (For contact with homeless/elderly/vulnerable members of the community)
- Community Policing (For interactions at events and members of the public)
- First Aid (CSOs represent SPD and should have basic CPR/First aid to assist the public)
- Signs of Influence
- Emotional Intelligence

In the future, SPD will implement a field training model to train new CSOs. At the program's inception, the department will rely on internal and external training to prepare the first batch of CSOs to execute

their job duties in a competent and professional manner. In the early stages of the program, the CSO Supervisors are tasked with developing a field training program and corresponding curriculum. It will be modeled after the field training model used by the former CSO Unit as well as the existing field training program for new officers. In the meantime, the CSO Supervisors will create and maintain a professional and constructive atmosphere for daily on-the-job training. They will also be responsible for providing consistent, honest, objective assessments of individual CSO performance.

Vehicles:

SPD has identified eight existing hybrid and electric vehicles for use by the CSO Unit on an interim basis. The CSO unit will have marked Ford Fusions but are currently utilizing Nissan Leaf's that are marked community service. Unfortunately, due to the pandemic the production of the Ford Fusions has been significantly delayed. CSOs will need transportation to deploy to all areas of the city. The CSO vehicle will be visibly and distinctly different from patrol vehicles. It will be easy to spot and identify as community service. The CSO unit vehicle will have a friendly appearance and carry outreach supplies to immediately meet the need of an individual. Outreach supplies would include resource guides for individuals experiencing homelessness, bus tickets, and small food items such as granola bars. The CSO unit vehicle will lack tactical supplies such as a caged back seat. It is the CSO unit's goal to use the vehicles for emergency transport, such as transporting domestic violence survivors or children who are being placed in Child Protective Service's custody. The CSO unit vehicles will be an essential part of reaching all parts of the community and assisting with keeping the community safe.

Uniforms:

The CSO uniform is a friendly light blue shirt and black pants. The uniform was carefully designed to have a friendly and approachable look. It was top priority in the uniform process that a CSO is clearly different than an officer in patrol. This was done for safety reasons, as well as to emphasize a CSOs approachability. CSO's have different badges and patches than sworn officers and parking enforcement. The patch and the badge were selected to stand out from other law enforcement officials and make CSOs easily identifiable. The patch was created by the CSO team and great thought was put into the design. The CSO patch is a light blue with a dark silhouette of the Seattle skyline having the space needle in the center. The patch also includes the water and Mount Rainier looking over the great city. The uniforms are currently in the process of being ordered. The CSO badge will have an eagle with its wings down and CSO in the center of the badge. For temporary uniforms the CSO's are wearing light blue polos with an SPD logo.

Community Service Officers during COVID 19:

SPD's CSO unit has been performing vital and essential duties during the COVID 19 pandemic. During the beginning of the Stay Home Stay Safe Order the unit received requests for assistance from the community in the International District. A community partner in the International District was in need of assistance packing and delivering food for low-income elders who struggled to leave their home in fear of getting the virus. The CSO unit quickly responded to the request for assistance, and spent a day

helping members of the International District pack and deliver food. CSOs helped deliver approximately one thousand meals that day. The impact was so incredible that the community partner asked for additional assistance the next week. CSOs have been assisting this community partner for several weeks to ensure low income elders are getting food during this difficult time.

The CSOs have been patrolling the precinct areas and checking in with business owners and community members. The CSO unit emphasizes the importance on connecting with the community and having transparent and open modes of communication. During routine patrol CSOs are having conversations with community members about community specific needs and concerns. There have been several businesses expressing their concern with crime in the area and being unsure how to get help. CSOs have been able to educate these business owners and community members about how to report crime and what to do if they feel a crime is occurring. Some of these businesses and community members were able to build trust with the CSOs and share serious concerns or crimes that had happened to them or someone they knew. Building trust within the community is an incredibly important task as a CSO, as the aim to build trust between the community and SPD. Being visible in the community during this pandemic is vital to letting the community know that the CSOs are here for them, even in the most trying times.

These checks have led to CSOs assisting other communities in the city with food delivery. Currently we are assisting individuals in the Filipino community deliver food to community members who are struggling during the pandemic. Each week CSOs deploy from SPD headquarters to community centers in the south precinct to pick up meals and groceries to deliver. The CSO unit is providing an essential and vital service to these individuals who need groceries. The COVID 19 pandemic has altered the CSO routine watch, but the unit has adapted to the needs of the community. Adapting to the needs of the community is one of the CSO units most important tasks, as they recognize communities and the city are ever changing.

During this pandemic, the CSO unit has strived to bring a smile to the community's face by participating in the Friday Night Lights events. The CSO unit aims to let the community know that they are there for them, no matter the circumstances.

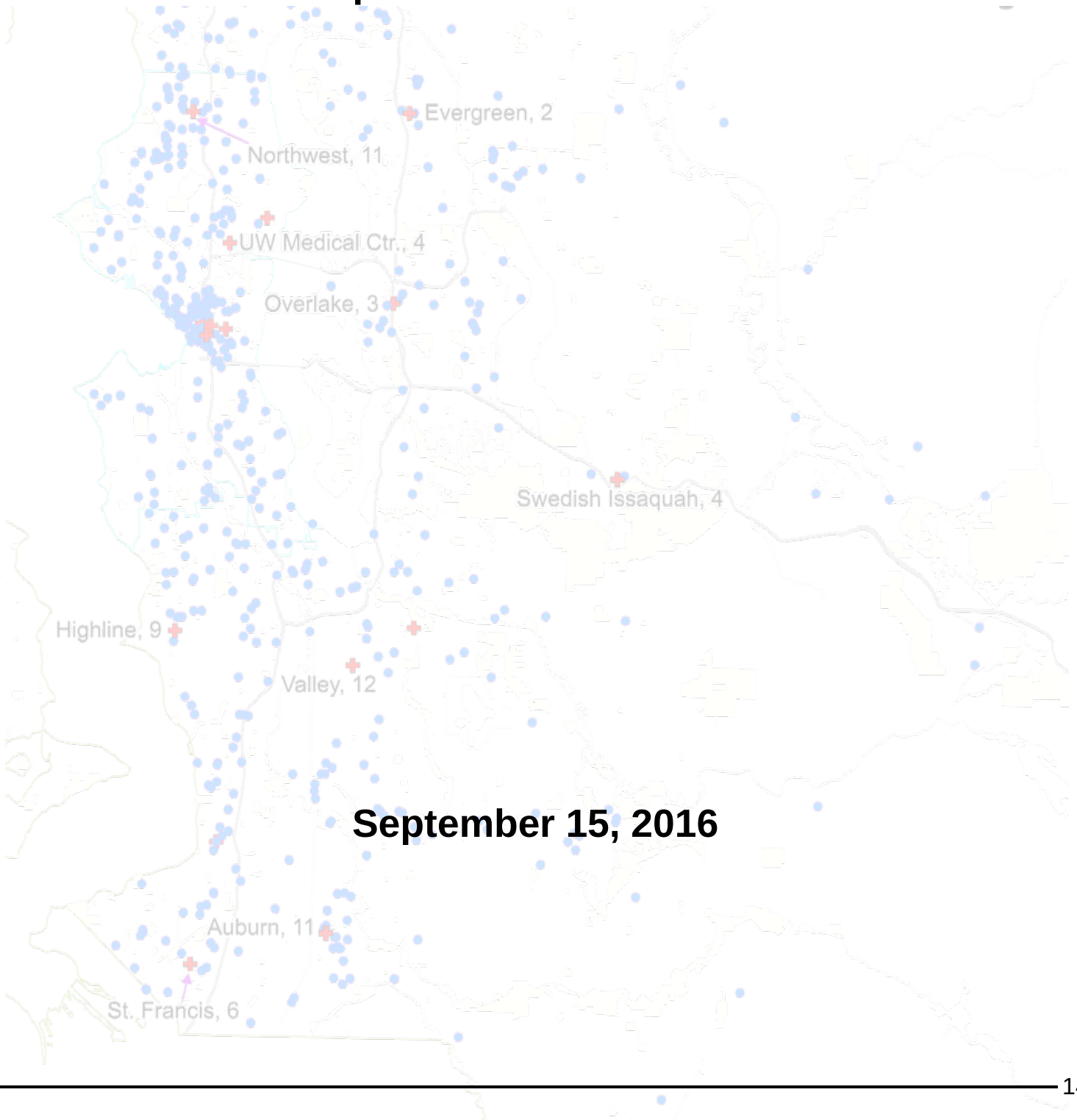
Legislation Text

File #: Inf 1688, **Version:** 1

Supervised Consumption Presentation

Heroin and Prescription Opiate Addiction Task Force

Final Report and Recommendations



September 15, 2016

Cover image: Deaths involving major drugs of abuse, King County, 2013-2015, from Caleb Banta-Green, University of Washington Alcohol and Drug Abuse Institute

Heroin and Prescription Opiate Addiction Task Force
Final Report and Recommendations
September 15, 2016

I. Executive Summary

Heroin and opioid use are at crisis levels in King County. In 2015, 229 individuals died from heroin and prescription opioid overdose in King County alone.[1] To confront this crisis, in March 2016, King County Executive Dow Constantine, Seattle Mayor Ed Murray, Renton Mayor Denis Law and Auburn Mayor Nancy Backus convened the Heroin and Prescription Opiate Addiction Task Force. The Task Force, co-chaired by the King County Department of Community and Human Services and Public Health – Seattle & King County, was charged with developing both short and long-term strategies to prevent opioid use disorder, prevent overdose, and improve access to treatment and other supportive services for individuals experiencing opioid use disorder.

Task Force participants included: All Home; American Civil Liberties Union; Auburn Police Department; City of Bellevue Fire Department; City of Seattle Mayor's Office; Department of Community and Human Services; Department of Social and Health Services, Children's Administration; Downtown Emergency Services Center; Evergreen Treatment Services; Harborview Medical Center; Hepatitis Education Project; Kelley-Ross Pharmacy; King County Adult Drug Diversion Court; King County Emergency Medical Services; King County Needle Exchange; Neighborcare Health; King County Prosecuting Attorney's Office; King County Sheriff's Office; Muckleshoot Tribe; People's Harm Reduction Alliance; Public Defender Association; Public Health – Seattle & King County; Puget Sound Educational Service District; Recovery Community; Renton Police Department; Seattle Children's; Seattle Fire Department; Seattle Human Services Department; Seattle Police Department; Seattle Public Schools; Swedish Hospital, Pregnant and Parenting Woman Program; Therapeutic Health Services; United States Attorney for Western Washington's Office; United States Department of Veterans Affairs, Veterans Health Administration; United States Substance Abuse and Mental Health Services Administration (SAMHSA); University of Washington Alcohol and Drug Abuse Institute (ADAI); Washington State Department of Social and Health Services, Behavioral Health Administration; and Washington State Health Care Authority.

The Heroin and Prescription Opiate Addiction Task Force met over a six month period from March to September 2016 to review 1) current local, state and federal initiatives and activities related to prevention, treatment and health services for individuals experiencing opioid use disorder; 2) promising strategies being developed and implemented in other communities; and 3) evidence-based practice in the areas of prevention, treatment and health services. The Task

[1] *2015 Drug Trends for King County, Washington, Caleb Banta-Green et al, Seattle: University of Washington Alcohol & Drug Abuse Institute, July 13, 2016. URL: http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf*

Force strived to avoid redundancy with other related activities and to leverage existing partnerships and activities where appropriate. Additionally, the Task Force applied an equity and social justice lens to the work to ensure that recommendations do not exacerbate, but rather lessen, inequities experienced by communities of color as a direct result of the "War on Drugs."

This report provides a summary of the group's recommendations to both prevent opioid addiction and improve opioid use disorder outcomes in King County.

Summary of the primary Task Force recommendations

Primary Prevention:

- Raise awareness and knowledge of the possible adverse effects of opioid use, including overdose and opioid use disorder;
- Promote safe storage and disposal of medications; and
- Leverage and augment existing screening practices in schools and health care settings to prevent and identify opioid use disorder.

Treatment Expansion and Enhancement:

- Create access to buprenorphine in low-barrier modalities close to where individuals live for all people in need of services;
- Develop treatment on demand for all modalities of substance use disorder treatment services; and
- Alleviate barriers placed upon opioid treatment programs, including the number of clients served and siting of clinics.

User Health and Overdose Prevention:

- Expand distribution of naloxone in King County; and
- Establish, on a pilot program basis, at least two Community Health Engagement Locations* (CHEL sites) where supervised consumption occurs for adults with substance use disorders in the Seattle and King County region. Given the distribution of drug use across King County, one of the CHEL sites should be located outside of Seattle.

* The Task Force will refer to sites that provide harm reduction services where supervised consumption occurs as Community Health Engagement Locations for individuals with substance use disorders (CHEL sites). This terminology recognizes that the primary purpose of these sites is to engage individuals experiencing opioid use disorder using multiple strategies to reduce harm and promote health, including, but not limited to, overdose prevention through promoting safe consumption of substances and treatment of overdose. The Task Force's equity and social justice (ESJ) charge emphases the importance of providing support and services to the most marginalized individuals experiencing substance use disorders in the County. The Task Force asserts that the designation CHEL sites is a non-stigmatizing term that recognizes that these sites provide multiple health interventions to decrease risks associated with substance use disorder and promote improved health outcomes.

II. Background

2016 Heroin and Prescription Opiate Addiction Task Force Formation: Partnership with King County and Cities of Seattle, Renton and Auburn

In March 2016, King County Executive Dow Constantine, Seattle Mayor Ed Murray, Renton Mayor Denis Law and Auburn Mayor Nancy Backus announced the formation of a Task Force of subject matter experts and stakeholders to confront the epidemics of heroin and prescription opioid addiction and overdose in King County.

Under the direction of the Executive and the Seattle, Renton and Auburn mayors, the Department of Community and Human Services (DCHS) partnered with Public Health – Seattle & King County to co-chair the Task Force. Task Force members represented multiple entities, including the University of Washington Alcohol and Drug Abuse Institute (ADAI), behavioral health services providers, hospitals, human service agencies, the recovery community, criminal justice partners, first responders, and others. Based on a review of evidence-based and evidence-informed practices and current strategies used in other communities, and building on recommendations established by Johns Hopkins Bloomberg School of Public Health[2] and the 2016 Washington State Interagency Opiate Plan[3], the Task Force developed recommendations to both prevent opioid addiction and improve opioid use disorder outcomes in King County.

Statement of the Problem

Opioid prescribing has increased significantly since the mid-1990s and has been paralleled by increases in pharmaceutical opioid misuse and opioid use disorder, heroin use, and fatal overdoses.[4] These increases in morbidity and mortality were seen among those who were prescribed opioids and those who were not. When opioid prescribing began decreasing between 2005-2010, the number of teens in Washington State reporting use of these medicines

[2] Alexander GC, Frattaroli S, Gielen AC, eds. The Prescription Opiate Epidemic: An Evidence-Based Approach. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland: 2015

[3] Department of Health. (2016). *Washington State Interagency Opiate Working Plan*. Retrieved from: http://stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf

[4] Jones, C. M., Mack, K. A. & Paulozzi, L. J. Pharmaceutical overdose deaths, United States, 2010. *JAMA* **309,** 657–9 (2013);
Paulozzi, L. J., Budnitz, D. S. & Xi, Y. Increasing deaths from opiate analgesics in the United States. *Pharmacoepidemiol. Drug Saf.* **15,** 618–27 (2006);
Paulozzi, L. J., Zhang, K., Jones, C. M. & Mack, K. A. Risk of adverse health outcomes with increasing duration and regularity of opiate therapy. *J. Am. Board Fam. Med.* **27,** 329–38 (2014); and
Jones, C. M., Paulozzi, L. J. & Mack, K. A. Sources of prescription opiate pain relievers by frequency of past-year nonmedical use United States, 2008-2011. *JAMA Intern. Med.* **174,** 802–3 (2014).

to “get high” also decreased. As pharmaceutical opioids became less available, some people with opioid use disorder switched to heroin because of its greater availability and lower cost.[5] Heroin, however, brings with it higher risks for overdose, infectious disease and, because it is illegal, incarceration.[6]

While these dynamics have affected individuals of all age groups, the impact is particularly striking for adolescents and young adults, with research indicating that youth ages 14-15 represent the peak time of initiation of opioid misuse.[7] Since 2005, this young cohort has represented much of the increase in heroin-involved deaths and treatment admissions in King County and Washington State.[8]

In King County, heroin use continues to increase, resulting in a growing number of fatalities. In 2013, heroin overtook prescription opioids as the primary cause of opioid overdose deaths. By 2014, heroin-involved deaths in King County totaled 156, “their highest number since at least 1997 and a substantial increase since the lowest number recorded, 49, in 2009.”[9] Increases in heroin deaths from 2013 to 2014 were seen in all four regions of the County, with a total increase from 99 to 156.[10] Heroin-involved overdose deaths in King County remain high with 132 deaths in 2015.[11] (See Attachment A for Map of Overdose Deaths in King County, 2013-2015.) Although prescription opioid-involved deaths have been dropping since 2008, many individuals who use heroin, and the majority of young adults who use heroin, report being hooked on prescription-type opioids prior to using heroin.[12]

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[5] Jones, C. M., Logan, J., Gladden, R. M. & Bohm, M. K. Vital Signs: Demographic and Substance Use Trends Among Heroin Users - United States, 2002-2013. *MMWR. Morb. Mortal. Wkly. Rep.* **64,** 719–25 (2015); and
Jones, C. M. Heroin use and heroin use risk behaviors among nonmedical users of prescription opiate pain relievers - United States, 2002-2004 and 2008-2010. *Drug Alcohol Depend.* **132,** 95–100 (2013).

[6] Jenkins, L. M. *et al.* Risk Factors for Nonfatal Overdose at Seattle-Area Syringe Exchanges. *J. Urban Heal.* **88,** 118–128 (2011); and
Cedarbaum, E. R. & Banta-Green, C. J. Health behaviors of young adult heroin injectors in the Seattle area. *Drug Alcohol Depend.* (2015). doi:10.1016/j.drugalcdep.2015.11.011

[7] McCabe, S. E., West, B. T., Teter, C. J. & Boyd, C. J. Medical and nonmedical use of prescription opiates among high school seniors in the United States. *Arch. Pediatr. Adolesc. Med.* **166,** 797–802 (2012); and
Meier, E. A. *et al.* Extramedical Use of Prescription Pain Relievers by Youth Aged 12 to 21 Years in the United States. *Arch. Pediatr. Adolesc. Med.* **166,** 803 (2012).

[8] Banta-Green, Caleb J., Kingston, Susan, Ohta, John, Taylor, Mary, Sylla, Laurie, Tinsley, Joe, Smith, Robyn, Couper, Fiona, Harruff, Richard, Freng, Steve, Von Derau, K. *2015 Drug use trends in King County Washington* (2016) at <http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>

[9] Drug Abuse Trends in the Seattle-King County Area: 2014. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, June 17, 2015. adai.uw.edu/pubs/cewg/DrugTrends_2014_final.pdf

[10] Drug Abuse Trends in the Seattle-King County Area: 2014. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, June 17, 2015. adai.uw.edu/pubs/cewg/DrugTrends_2014_final.pdf

[11] Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf

[12] Peavy KM, Banta-Green CJ, Kingston S, Hanrahan M, Merrill JO, Coffin PO. “Hooked on Prescription-Type Opiates Prior to Using Heroin: Results from a Survey of Syringe Exchange Clients,” *Journal of Psychoactive Drugs*, 2012:44(3):259-65, and Cedarbaum ER, Banta-Green CJ, “Health Behaviors of Young Adult Heroin Injectors in the Seattle Area,” Drug Alcohol Depend [Internet] 2015 [cited 2015 Dec 18]; available from http://www.ncbi.nlm.nih.gov/pubmed/26651427

According to the Centers for Disease Control and Prevention, more people die In the United States of drug-related overdose than from auto accidents, a difference that has been growing since 2008. In 2000, there were more than 40,000 traffic-related deaths and fewer than 20,000 from drug overdose; in 2013 there were 43,982 overdose-related deaths and 32,719 traffic fatalities.[13]

From 2010 to 2014 the number of people who entered the publicly funded treatment system for heroin use disorders annually in King County grew from 1,439 to 2,886. This increase occurred while the number of people receiving treatment for all other primary drugs of choice declined (except for people with methamphetamine use disorders).[14] In fact, for the first time, heroin treatment admissions surpassed alcohol treatment admissions in 2015. The majority of those entering treatment for heroin for the first time were ages 18-29; among this age group, half reported injecting and half reported smoking heroin, a pattern that began slowly emerging in 2009.[15] Heroin is also the most commonly mentioned drug among callers to the County Recovery Help Line, totaling 2,100 in 2015, almost double the number in 2012. [16]

Opioid treatment programs (OTP) that dispense methadone and buprenorphine in King County have been working to expand capacity, and the number of admissions to these programs increased from 696 in 2011 to 1,486 in 2014.[17] As of October 1, 2015, there were 3,615 people currently maintained on methadone at an OTP in King County.[18] Statutory capacity limitations have historically resulted in up to 150 people on a waitlist. Buprenorphine is another proven opioid use disorder medication that cuts the odds of dying in half compared to no treatment or counseling only.[19] It can be provided at an OTP but, unlike methadone, it can also be prescribed by a physician in an office-based setting and obtained at a pharmacy. Requests for buprenorphine treatment by callers to the County Recovery Help Line have increased from 147 in 2013 to 363 in 2015.[20] Treatment capacity for buprenorphine is limited and far exceeded by demand.

[13] Center for Disease Control. (2015, April 30). Injury Prevention & Control: Prescription Drug Overdose Retrieved from http://www.cdc.gov/drugoverdose/data/overdose.html
[14] TARGET database, Washington State Publically funded treatment, Division of Behavioral Health and Recovery.
[15] Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf
[16] Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf
[17] TARGET database, Washington State Publically funded treatment, Division of Behavioral Health and Recovery.
[18] TARGET database, Washington State Publically funded treatment, Division of Behavioral Health and Recovery.
[19] Pierce, M., Bird, S. M., Hickman, M., Marsden, J., Dunn, G., Jones, A., and Millar, T. (2016) Impact of treatment for opiate dependence on fatal drug-related poisoning: a national cohort study in England. Addiction, 111: 298–308.
[20] Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf

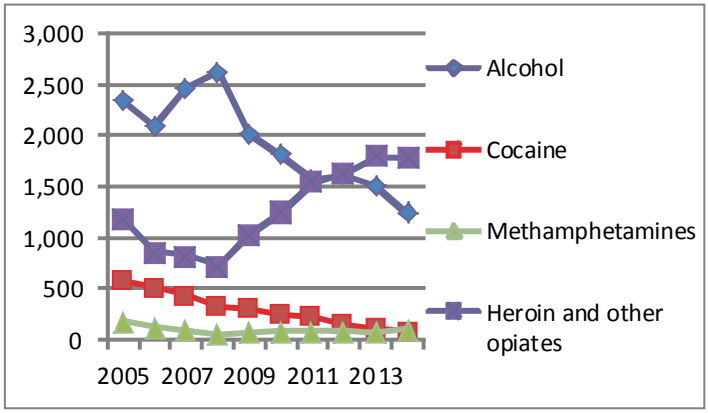


Figure 1: Heroin has Surpassed Alcohol as Primary Drug Reported on Admission to Detoxification Services in King County

In addition to being the leading reason for entering a drug treatment program, heroin is now also the primary drug used by people seeking withdrawal management (detoxification) in the King County publicly funded treatment system, surpassing alcohol.[21] Also, people seeking opioid withdrawal management are younger than in previous years. According to the King County Substance Abuse Prevention and Treatment Annual Report, "From the first half of 2008 through the second half of 2011, there was a steady increase in the number and percentage of young adults under 30 years old entering detoxification services. The numbers and percentages of young adults leveled off during 2012, and have remained at higher levels. Among all individuals admitted in 2014, *85% of those younger than 30 years old indicated opioids are their primary drug used* compared to 41% of those 30 years or older."[22]

Syringe exchange services remain a readily accessible effective health intervention and the demand for this service continues to grow. Close to six million clean syringes are handed out annually in King County.[23] In a recent Washington State survey of syringe exchange users, 75% were interested in getting help reducing or stopping their use, yet only 14% were enrolled in treatment.[24]

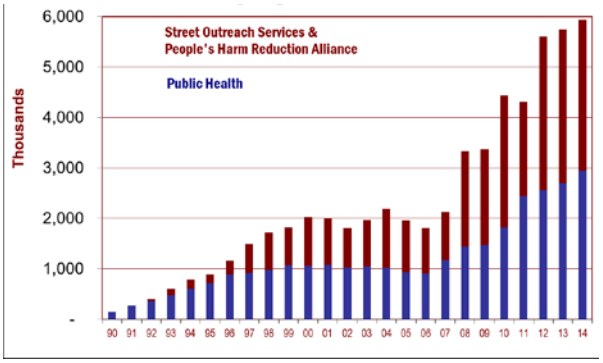


Figure 2 Syringe Exchange data 1989-2014, King County, WA

Homelessness is also a persistent problem in our community. The 2016 King County One Night Count found that 4,505 of our neighbors in King County were without shelter this year, a 19% increase over 2015. While the leading cause of death among homeless Americans used to be HIV, it is now drug overdose. A study in JAMA Internal Medicine found that overdoses, most of which involved opioids, are now responsible for the majority of deaths among individuals experiencing homelessness in the Boston area. The same trend is occurring locally, as documented in the death reports of individuals experiencing homelessness in King County.

[21] TARGET database, Washington State Publically funded treatment, Division of Behavioral Health and Recovery.
[22] King County Mental Health, Chemical Abuse and Dependency Services Division. Substance Abuse Prevention and Treatment Annual Report, 2014
[23] Drug Abuse Trends in the Seattle-King County Area: 2014. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, June 17, 2015. adai.uw.edu/pubs/cewg/DrugTrends_2014_final.pdf
[24] Results from the 2015 Washington State Drug Injector Health Survey, February 2016. Kingston, S. and Banta-Green, C. Alcohol and Drug Abuse Institute, Univ. of Washington. http://adai.uw.edu/pubs/infobriefs/2015DrugInjectorHealthSurvey.pdf

While the causes of homelessness are multi-faceted and complex, substance abuse is both a contributing cause and result of homelessness.

There is an urgent need for action. Fortunately, a variety of evidence-based interventions exist that have demonstrated effectiveness at helping individuals reduce opioid use and decrease related harms. Identifying creative ways to expand the use of, and access to, effective interventions is paramount to curbing the effects of heroin and other opioids in the community.

Building on History and Current Actions

From 1999 to 2001, then Seattle Mayor Paul Schell and King County Executive Ron Sims convened a multi-sector task force to address the rise in heroin use in the community. The group generated a set of recommendations to address the heroin epidemic. In 2007, the King County Board of Health adopted a Resolution on HIV / AIDS that endorsed a Public Health King County *Strategic and Operational Plan for HIV Prevention in King County,* which supported addressing harm from intravenous drug use through different health promotion and prevention activities.[25] In 2015, a Washington State Interagency Opiate Working Plan was drafted by a collaboration of the Department of Health, Division of Behavioral Health and Recovery and the University of Washington Alcohol and Drug Abuse Institute. Additionally, in 2015 a legislative workgroup was convened by state Representatives Brady Walkinshaw and Strom Peterson along with state Senator David Frockt to develop strategies to address the need to help people engage in opioid treatment and reduce overdose. This current Task Force drew from those initiatives and leveraged other activities and partnerships to develop a plan to respond to the region's growing heroin and opioid addiction problem.

III. 2016 Heroin and Prescription Opiate Addiction Task Force Charge

Responding to the direction of the sponsors of the 2016 Heroin and Prescription Opiate Addiction Task Force to confront the heroin and opioid epidemic with immediate action, the Task Force identified specific focus areas based on their potential to have the broadest and most meaningful public health impact on the region's heroin epidemic. The specific areas of focus are:

A. Primary Prevention (of opioid use disorders)
- Prescriber education
- Public education for adults and youth
- Prescription drug take-back (aka secure medication return)
- Enhancing screening for opioid misuse and opioid use disorder

B. Treatment Expansion and Enhancement
- Treatment on demand for all needed modalities of treatment
- Innovative buprenorphine prescribing practices

[25] Final Report and Recommendations: September 20, 2007. King County Board of Health HIV/AIDS Committee

C. User Health Services and Overdose Prevention

- Expansion of access to naloxone
- Community Health Engagement Locations for individuals with substance use disorders (CHEL sites) where supervised consumption occurs

Task Force members agreed that their work and recommendations must be directly influenced by equity and social justice considerations. The Task Force developed the following equity and social justice charge:

> The Task Force will apply an Equity and Social Justice (ESJ) lens to all of its work. We acknowledge that the "War on Drugs" has disproportionately adversely impacted some communities of color, and it is important that supportive interventions recommended now not inadvertently replicate that pattern. Interventions to address the King County heroin and opioid problem will or could affect the health and safety of diverse communities, directly and indirectly (through re-allocation of resources). Measures recommended by the Task Force to enhance the health and well-being of heroin and opioid users or to prevent heroin and opioid addiction must be intentionally planned to ensure that they serve marginalized individuals and communities. At the same time, the response to heroin and opioid use must not exacerbate inequities in the care and response provided among users of various drugs. All recommendations by the Task Force will be reviewed using a racial impact statement framework. The Task Force will not seek to advance recommendations that can be expected to widen racial or ethnic disparities in health, healthcare, other services and support, income, or justice system involvement. Whenever possible, these concerns should lead to broadening the recommendations of the Task Force, rather than leaving behind interventions that are predicted to enhance the health and well-being of heroin and opioid users.

IV. SUMMARY OF TASK FORCE PROCESS

The Executive and mayors of Seattle, Renton and Auburn, in conjunction with the Departments of Community and Human Services and Public Health – Seattle & King County, appointed members to the Task Force from the following entities:

1. All Home
2. American Civil Liberties Union
3. Auburn Police Department
4. City of Bellevue Fire Department
5. City of Seattle Mayor's Office
6. Department of Community and Human Services
7. Department of Social and Health Services, Children's Administration
8. Downtown Emergency Services Center
9. Evergreen Treatment Services

10. Harborview Medical Center
11. Hepatitis Education Project
12. Kelley-Ross Pharmacy
13. King County Adult Drug Diversion Court
14. King County Emergency Medical Services
15. King County Needle Exchange
16. King County Prosecuting Attorney's Office
17. King County Sheriff's Office
18. Muckleshoot Tribe
19. Neighborcare Health
20. People's Harm Reduction Alliance
21. Public Defender Association
22. Public Health – Seattle & King County
23. Puget Sound Educational Service District
24. Recovery Community
25. Renton Police Department
26. Seattle Children's
27. Seattle Fire Department
28. Swedish Hospital, Pregnant and Parenting Woman Program
29. Seattle Human Services Department
30. Seattle Police Department
31. Seattle Public Schools
32. Therapeutic Health Services
33. United States Attorney for Western Washington's Office
34. United States Department of Veterans Affairs, Veterans Health Administration
35. United States Substance Abuse and Mental Health Services Administration (SAMHSA)
36. University of Washington Alcohol and Drug Abuse Institute (ADAI)
37. Washington State Department of Social and Health Services, Behavioral Health Administration
38. Washington State Health Care Authority

The Task Force met five times between March and September 2016 and was chaired by Brad Finegood, M.A. (Assistant Director of the King County Behavioral Health and Recovery Division, Department of Community and Human Services, DCHS) and Dr. Jeff Duchin, M.D. (Health Officer, Public Health – Seattle & King County, PHSKC). A list of the Task Force members is provided in Attachment B.

Three workgroups were initially formed to address the Task Force's three focus areas (opioid abuse prevention, treatment expansion and enhancement, and health services and overdose prevention). These workgroups were comprised of Task Force members with related subject matter expertise, and met between full Task Force meetings. The prevention workgroup was led by Dr. Caleb Banta-Green, Ph.D. (University of Washington), and met four times between April and August 2016. The treatment expansion and enhancement workgroup was led by Brad Finegood, M.A. and met eight times between April and August 2016. The workgroup addressing health services and overdose prevention of individuals using opioids was led by Dr. Jeff Duchin,

M.D., and met nine times between April and August 2016. DCHS and PHSKC staff members provided support to the workgroups.

A fourth workgroup was formed to address policy considerations associated with expanding the County's capacity for treatment, health services, and overdose prevention of individuals using opioids. This workgroup was led by Brad Finegood and was comprised of Task Force members and non-Task Force subject matter experts. The policy workgroup met four times between May and August 2016. A fifth workgroup was formed to plan for evaluation of recommendations implemented by the sponsors. This workgroup was led by Caleb Banta-Green and was also comprised of Task Force members and non-Task Force subject matter experts. A list of the five workgroups and their respective members is included in Attachment C.

During the course of the Task Force process, a series of community meetings was held in order to 1) provide public education about heroin and opioid addiction, treatment and health services, and/or 2) to obtain community input as the Task Force developed strategies and meaningful solutions to the problem of addiction and overdose in King County. Community meetings included the following:

- Presentation on the Heroin and Prescription Opiate Addiction Task Force to legislative staff, which was held at Sea Mar Community Health Center in Des Moines, Washington on August 16, 2016
- The Sound Cities Administration Meeting, which was held in Renton on July 5, 2016
- Presentation on Practical Implementation of an Agency Opiate Overdose Response Policy at the Washington State Behavioral Healthcare Conference in Yakima on June 23, 2016
- A Community Conversation about Addiction and Recovery, which was held at Thomas Jefferson High School in Auburn on June 9, 2016
- The Heroin Epidemic: A Community Conversation, which was held at the Museum of History and Industry in Seattle on June 6, 2016 (aired on public television on July 5, 2016)
- Community Conversation: Heroin and Prescription Opiate Overdose and Addiction, which was sponsored and facilitated by the Heroin and Prescription Opiate Addiction Task Force, and held at the Renton Community Center on May 31, 2016 (See Attachment D for Community Conversation [May 31, 2016]: Attendee Comments.)
- Presentation on the Heroin Epidemic and Local Efforts at a summit sponsored by the Seattle Municipal Court bench, held at the Seattle Municipal Court on May 20, 2016.
- Presentation on Medication-Assisted Treatment Services and the Opiate Epidemic at the Kent Municipal Court on May 13, 2016
- Presentation on the Heroin Epidemic at the Seattle University Symposium: Addressing Seattle's Urban Disorder with Collective Efficacy Principles on May 6, 2016
- The Recovery Café Community Conversation and Screening of Frontline Documentary Chasing Heroin, which was held at the Recovery Café in Seattle on May 2, 2016
- Presentation on Practical Implementation of an Agency Opiate Overdose Response Policy at the statewide Conference on Ending Homelessness in Spokane on May 11, 2016

- Presentation on the Heroin Epidemic and Local Efforts to the Ballard Community Taskforce on Homelessness and Hunger, which was held at the Nyer Urness House on April 28, 2016
- Presentation on Medication-Assisted Treatment Services at The Heroin Epidemic: New Challenges for the Courts, hosted by the Lake Forest Park Municipal Court on April 11, 2016
- Presentation on the Heroin Epidemic and Local Efforts to the King County Regional Law Safety and Justice Committee at Seattle City Hall on March 31,2016
- Lessons from the North: Canada's Safe Consumption Space, Harm Reduction, and Seattle's Crisis, which was held at 12 Ave Arts of Capitol Hill Housing in Seattle on March 23, 2016
- Leading the Way: Public Health & Safety Approaches to Drug Policy Locally, Nationally, and Abroad, which was held at Seattle University on March 22, 2016
- Better is Better: Harm Reduction, Safe Consumption, and the Heroin Epidemic, which was held at the University of Washington on March 21, 2016
- Seattle City Council Lunch and Learn with Insite Co/Founders, which was held at Seattle City Hall on March 21, 2016

Task force members also utilized various media venues (including radio, television, print and social media) to discuss the heroin epidemic and efforts to address this issue.

V. Recommendations

Task Force recommendations were generated by the Primary Prevention workgroup, Treatment Expansion and Enhancement workgroup, and User Health Services and Overdose Prevention workgroup, in collaboration with Policy and Evaluation workgroups. Workgroup recommendations were presented to the full Task Force on two separate occasions for review, feedback and modification, culminating in a final vote on each recommendation. The Task Force Chairs determined that approval of recommendations would be based on achievement of a simple majority of voting members of the Task Force. Attachment B displays the voting members of the Task Force. City of Seattle and King County employees that report to the Task Force conveners did not vote on the final recommendations, although they participated in work group deliberations. Additionally, the U.S. Attorney for Western Washington, Annette Hayes, participated as a non-voting member. In total, seven recommendations were approved during a Task Force meeting and one recommendation was approved by e-mail vote. (See Attachment E for Summary of Recommendation Voting Tally.)

Primary Prevention Workgroup Recommendations

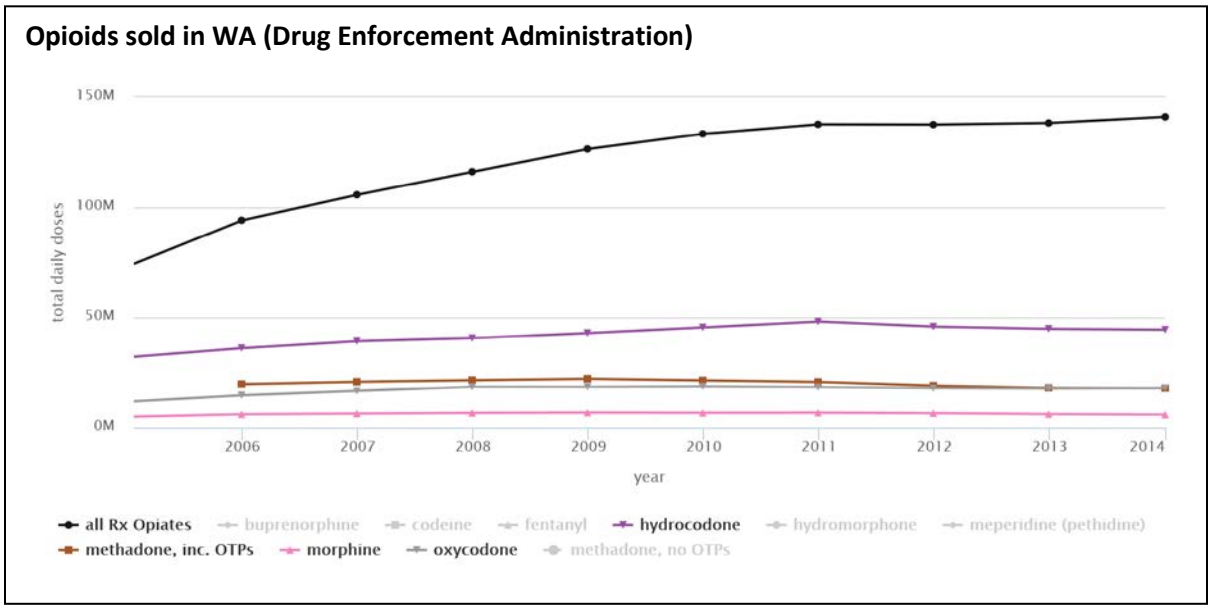
1. **<u>Raise awareness and knowledge of the possible adverse effects of opioid use, including overdose and opioid use disorder.</u>**

   Goals:

   - Opioid prescribing is appropriate in terms of who receives prescriptions, indications for treatment, and the type, amount and duration of opioid prescribed.
   - Prescribers and those they serve will have sufficient understanding of evidence-based risks and benefits of opioids, other pain management strategies, and screening for opioid use disorder and overdose risks to make appropriate decisions regarding opioids.
   - Parents of adolescents and children will receive information adequate to understand the risks and benefits of opioids for acute pain, other pain management strategies, as well as information on safe storage and disposal.

   Rationale:

   - Opioid prescribing has increased dramatically over the past 20 years. In recent years, the increase has plateaued in Washington State (see Figure below). However, the overall increase in prescribing of opioids over the last 20 years has contributed to increased misuse, opioid use disorder, and fatal overdoses among both those who were prescribed and not prescribed opioids.[26]



[26] Jones, C. M., Mack, K. A. & Paulozzi, L. J. Pharmaceutical overdose deaths, United States, 2010. *JAMA* **309,** 657–9 (2013).
Paulozzi, L. J., Budnitz, D. S. & Xi, Y. Increasing deaths from opioid analgesics in the United States. *Pharmacoepidemiol. Drug Saf.* **15,** 618–27 (2006).
Paulozzi, L. J., Zhang, K., Jones, C. M. & Mack, K. A. Risk of adverse health outcomes with increasing duration and regularity of opioid therapy. *J. Am. Board Fam. Med.* **27,** 329–38 (2014).
Jones, C. M., Paulozzi, L. J. & Mack, K. A. Sources of prescription opioid pain relievers by frequency of past-year nonmedical use United States, 2008-2011. *JAMA Intern. Med.* **174,** 802–3 (2014).

- Education and improved opioid prescribing may help reduce the risk of substance misuse while providing appropriate pain management.
- Providers who have registered for and use Washington's Prescription Drug Monitoring Program (PDMP) will have an informed understanding of the individual's prescription opioid use history and will be better able to assess risk for overdose and indications of possible misuse resulting in improved care. Washington regulations[27] state:

  The physician shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic non-cancer pain.

  (2) The patient's health history should include:

  (a) A review of any available prescription monitoring program or emergency department-based information exchange
- Education and support is critical to prevention and allows the individual seeking services to have an active role in their care and to recognize warning signs of opioid misuse.
- Impacting inappropriate opioid access requires behavior changes on the part of prescribers, patients, and family/household members. These same people should also be involved in addressing motivation to use opioids, including ways to think about and respond to physical and emotional pain as well as social pressures.
- Opioid misuse is currently an epidemic and prescribers and/or healthcare professionals across all settings play a key role in raising awareness. To reach all consumers, prevention practices should be implemented universally across settings and populations to address equity and social justice concerns.
- Concerns regarding opioids need to be balanced with the need for adequate pain control, especially in light of evidence of disparities in accessing opioid medication for pain, particularly for African Americans.

Approach:

- Coordinate with governmental agencies, professional organizations, medical/dental/nursing schools, health care training institutes, and health care systems to educate physicians on responsible opioid prescribing practices and pain management oversight.
- Create and distribute an educational flyer and counseling guide for use during opioid prescribing visits (medical /dental office or pharmacy) that addresses risk for overdose, addiction potential and other risk factors for those with pain conditions who are potential candidates for opioids. (See Attachment F for Implementation and Planning Details.)
- Encourage providers to register and use the PDMP. Increased outreach efforts will occur through King County Public Health and DCHS staff to professional organizations to inform them of the availability and utility of the PDMP and encourage utilization.

[27] http://app.leg.wa.gov/wac/default.aspx?cite=246-919-853

- Launch education campaign to reach broad audience including the general public, individuals using opioids, social networks, and professionals. (See Attachment F for Implementation and Planning Details.)
- Distribute counseling guidelines and other tools to pharmacists, behavioral health specialists, and other healthcare professionals and encourage them to provide education on prescription opioid safety (storage, disposal, overdose prevention, risk factors for addiction, and response to overdose).

2. <u>Promote safe storage and disposal of medications.</u>

Goals:

- Prevent access to and initiation of opioids by those not prescribed the medication.
- Prevent opioid overdoses.

Rationale:

- The number of non-medical users of opioid pain relievers (4.5 million in 2013 per the Substance Abuse and Mental Health Services Administration (SAMHSA) is high. Youth and adults access these medications through medicine cabinets, homes and sharing.
- Limiting access to opioids can potentially prevent misuse and inappropriate initiation among adolescents. The physical and mental health consequences of opioid misuse are significant, including fatal overdoses and opioid use disorder.
- Research indicates that the ages of 14-15 years represent the peak time of initiation of opioid misuse.[28] Adolescents who initiated misuse of opioids between 2005-2010 now represent many of the young adults dying from heroin involved overdoses or entering treatment across King County and Washington State.[29] Washington data indicate that 5% of 10th graders in 2014 reported using prescription-type opioids to get high in the past month and that there was a strong correlation with using heroin at some point in time (see figure on page 15). Note that in 2006 10% of 10th graders reported past month use and that the decline over time coincides closely with declines in prescribing of potent opioids in Washington state.
- A majority of individuals using heroin report initially using pharmaceutical opioids.
- Universal education should help de-stigmatize discussing opioid safety. Focusing educational messages on the inherent dangers of opioids may make individuals more receptive to messaging and more likely to change behaviors.
- Note there is no known published research on the effectiveness of interventions to specifically prevent abuse of pharmaceutical opioids or heroin.

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[28] McCabe, S. E., West, B. T., Teter, C. J. & Boyd, C. J. Medical and nonmedical use of prescription opioids among high school seniors in the United States. *Arch. Pediatr. Adolesc. Med.* **166,** 797–802(2012); and
Meier, E. A. *et al.* Extramedical Use of Prescription Pain Relievers by Youth Aged 12 to 21 Years in the United States. *Arch. Pediatr. Adolesc. Med.* **166,** 803 (2012).

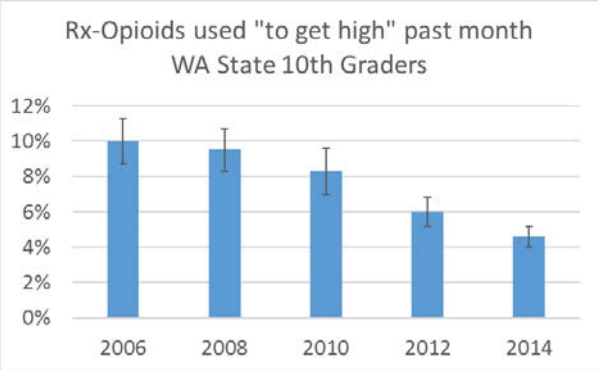
[29] Banta-Green, Caleb J., Kingston, Susan, Ohta, John, Taylor, Mary, Sylla, Laurie, Tinsley, Joe, Smith, Robyn, Couper, Fiona, Harruff, Richard, Freng, Steve, Von Derau, K. *2015 Drug use trends in King County Washington*. (2016). at <http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf>

Approach:

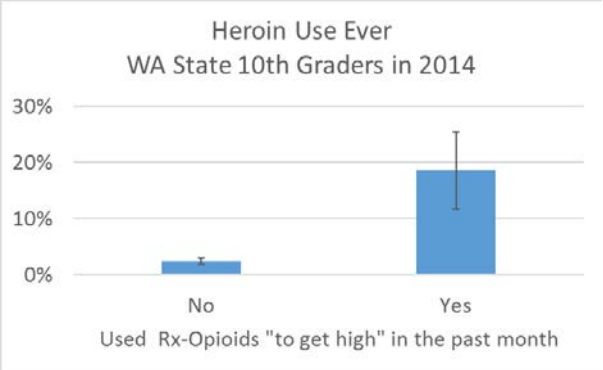
- Encourage pharmacies to provide counseling on safe storage and disposal of opioids and other controlled substances at the time of a first prescription in order to prevent unintended access to these medications. (See Attachment G for Implementation and Planning Details.)
- Increase pharmacy participation in promoting safe storage and medicine disposal to expand community awareness across all areas in the County.

Trends in the use of Rx-type opiates to "get high" among 10th graders and the association with heroin use

The proportion of 10th graders reporting using prescription-type opioids to get high in the past month declined significantly from 10% to 5% from 2006-2014



Among 10th graders those who reported they had used prescription-type opioids to get high in the past month 19% had ever used heroin, compared to 3% among those not using prescription-type-opioids to get high.



SOURCE: Healthy Youth Survey, analysis Alcohol and Drug Abuse Institute, University of Washington

- Expand access to prescription-take-back programs via King County Secure Medication Return locations and mail back envelopes. Coordinate and collaborate with the King County Secure Medication Return program to ensure population wide education and pharmacy based education. Incorporate consistent guidance on safe disposal methods for medications.
- In addition to providing education on the importance of disposal of unused and unwanted medication, engage local pharmacies to distribute mail-back envelopes with each opioid prescription dispensed.
- Use social media to promote safe storage and disposal of medications.
- Background Information
  - Sample education materials (to be amended with King County info) http://here.doh.wa.gov/materials/safe-use-of-prescription-pain-medication
  - Overview of trajectories of adolescent use and misuse of opioids http://archpedi.jamanetwork.com/article.aspx?articleid=1149405

3. Leverage and augment existing screening practices in schools and health care settings to prevent and identify opioid use disorder.

Goals:

- Identify youth who are at risk for developing opioid-related problems or who have developed opioid use disorder, using validated screening tools.
- Increase access to substance use disorder assessment and treatment, regardless of income, and provide appropriate services, brief interventions and referrals for them.

Rationale:

- Behavioral health agencies, primary care clinics, hospitals and other service organizations are currently providing screenings for substance use disorders.
- Non-medical use of opioids peaks between the ages of 14-16 indicating that screening needs to occur prior to and during adolescence http://www.ncbi.nlm.nih.gov/pubmed/22566514 .
- Treatment of substance use disorder is most effective when identification, referrals, and interventions are delivered during the early stages.
- Behavioral health agencies deliver school-based services in a number of middle schools and high schools in King County. Because opioids are so prevalent and initiation often happens among teens, it is important to identify, as early as possible, those who are at risk for or already misusing opioids. Providers delivering services in these settings are not always aware of opioid-related resources or equipped with tools to discuss opioid use.
- Behavioral health agencies can engage clients in a brief intervention and educational dialogue for those that screen positive for opioid misuse and/or related risk factors.
- Seattle Public Schools has social-emotional development curriculum for students that addresses holistic healthy development. There is opportunity to enhance this education and open dialogue in an existing practice within schools.
- Education and support is critical to prevention and allows individuals to have an active role in their care and recognize warning signs and risks of opioid misuse.
- Community education reduces stigma associated with use, promotes public health, helps individuals recognize the complexity of the issue, and empowers people to ask for help.
- To reach all consumers prevention practices should be universal to address equity and social justice concerns.

Approach:

- Expand existing school based screening, brief interventions and referrals for substance use, to include accurate and actionable information related to opioid misuse.
- Work with schools to have information available to students and families.
- Provide professionals with training on opioid use disorders, local resources, and interventions, including research-backed interventions for opioid use disorder.
- Explore opportunities to expand screening to other settings and populations.

- Work with the Department of Social and Health Services Children's Administration on referral process for high risk youth for substance use disorder treatment.

Treatment Expansion and Enhancement Recommendations

1. <u>Create access to buprenorphine for all people in need of services, in low-barrier modalities close to where individuals live.</u>

Goal:

- Individuals experiencing opioid use disorder, who desire opioid agonist pharmacotherapy with buprenorphine, will have access to treatment on demand. Treatment on demand is defined as the individual meeting with a prescriber immediately, or on day one or day two, to initiate treatment.

Rationale:

- This recommendation would expand access to buprenorphine, an evidence-based treatment for opioid use disorder. Unlike methadone treatment, which is restricted to a limited supply of licensed programs, buprenorphine treatment can be prescribed by a general physician in an office-based setting. [30]
- This recommendation would support treatment on demand by establishing access points for treatment induction, coordination and maintenance of care at behavioral health clinics, community health clinics, emergency rooms, and other sites already frequented by individuals with opioid use disorder seeking opioid agonist pharmacotherapy.
- This recommendation would address equity and social justice concerns, as evidence demonstrates racial/ethnic and socioeconomic disparities in use of buprenorphine for treatment of opioid use disorder. [31] In particular, data suggest that individuals receiving buprenorphine for treatment of opioid use disorder are more likely to be white and have higher incomes than those receiving methadone. Expanding geographic access points to include health care providers that serve traditionally underserved people throughout King County would alleviate this disparity.
- This recommendation has the potential to reduce stigma associated with treatment of opioid use disorder, as individuals can obtain treatment outside of federally regulated methadone clinics if desired, and providers would obtain training on treatment of addiction that they could integrate into their general practice of medicine.
- This recommendation would support ongoing efforts in the community to achieve integrated and holistic care (mental health, substance use, and primary care treatment services) for persons with physical and behavioral health problems.

[30] Alexander GC, Frattaroli S, Gielen AC, eds. The Prescription Opioid Epidemic: An Evidence-Based Approach. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland: 2015

[31] Hansen, H. B., Siegel, C. E., Case, B. G., Bertollo, D. N., DiRocco, D., & Galanter, M. (2013). Variation in use of Buprenorphine and Methadone Treatment by Racial, Ethnic and Income Characteristics of Residential Social Areas in New York City. *The Journal of Behavioral Health Services & Research*, *40*(3): 367-377.

- This recommendation, which supports the creation of low-barrier treatment, has the potential to engage individuals in opioid use disorder treatment and other supportive services who may not engage in traditional substance use disorder treatment.
- This recommendation, which increases access to effective treatment, has the potential to reduce harm associated with untreated opioid addiction, including fatal overdose,[32] infectious disease and other health complications, and incarceration.

Approach:

- Utilize multiple access points to facilitate buprenorphine induction and maintenance. This approach is informed by the San Francisco Integrated Buprenorphine Intervention Services (IBIS) program (see Attachment H for IBIS Process Protocol), adapted to meet the needs of our local communities. Level 1 facilities will focus on induction of buprenorphine for individuals experiencing opioid use disorder in a low-barrier modality. A Level 1 facility would provide frequent dosing of buprenorphine treatment until an individual has stabilized. Once stabilized on buprenorphine treatment, an individual may transfer their care to a Level 2 or Level 3 facility of their choice to continue buprenorphine services with a less frequent dosing regimen (referred to as buprenorphine maintenance services). Importantly, induction will not be restricted to Level 1 facilities; individuals may also access induction services at Level 2 and Level 3 facilities.
- Centralized client care coordination across the system will be necessary to ensure treatment on demand and successful transfer of buprenorphine services from a Level 1 facility to a Level 2 or 3 Facility. One current model that could be built upon is the Recovery Help Line. The Recovery Help Line offers 24-hour emotional support and referrals to local treatment services. (See Attachment I for Buprenorphine System of Care: Implementation and Planning Details associated with establishing buprenorphine services in Level 1 through Level 3 Facilities.)

  Level 1 Facilities
  - Downtown Public Health Needle Exchange Induction Site
  - Emergency Department Induction Sites
  - Recovery Center Valley Cities Detox and Residential Facility
  - Mobile Medical Van
  - King County Correctional Facilities

  Level 2 Facilities
  - Community Health Clinics (CHCs)

  Level 3 Facilities
  - Behavioral Health Clinics, including traditional medication-assisted treatment (MAT) facilities

[32] Banta-Green, C. J., and Coffin, P. O. (2016) Commentary on Pierce et al. (2016): Raising the bar of addiction treatment—first do no harm. *Addiction*, 111: 309–310.

- A **"buprenorphine first"** model of care aims to use buprenorphine treatment induction and stabilization as the priority health intervention. A traditional approach to treatment has provided quality care to a subset of the overall population of individuals with opioid use disorder who are able to consistently and predictably engage in treatment and adhere to stringent treatment requirements (regular appointment attendance, urinalysis testing, etc.). However, individuals who 1) are experiencing homelessness, 2) have limited or no support systems, and/or 3) have complex medical and behavioral health needs may experience difficulty successfully engaging and receiving care at traditional opioid treatment programs. A "buprenorphine first" model of care is an alternative approach to opioid treatment that is client-centered, focused on harm reduction, and designed to engage a greater number of individuals experiencing opioid use disorder in effective opioid treatment.

- A **collaborative care** model, which utilizes nurses or other professionals in innovative care management models, has been successfully implemented in other communities to expand treatment access and is the preferred approach to support delivery of buprenorphine services (see Attachment J, Description of Collaborative Care/Nurse Care Manager Model).[33] The use of the collaborative care/nurse care manager (NCM) model addresses numerous major barriers to buprenorphine prescribing that prescribers face, including insufficient time and support to accomplish the necessary steps to initiate and maintain a client in treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided guidance on the specific role that nurse case managers can play in conducting screening, assessment, treatment monitoring, counseling, education, and other supportive services to facilitate office-based buprenorphine treatment of opioid use disorder.[34]

- Healthcare facilities without on-site buprenorphine (waivered) prescribers could enter into agreements with waivered prescribers to provide buprenorphine services via telehealth technology. This would improve access to buprenorphine services for individuals experiencing opioid use disorder who reside in rural or underserved areas.

2. <u>Develop Treatment on Demand for all Modalities of Substance Use Disorder Treatment Services</u>

Goal:

- Individuals experiencing opioid use disorder who desire opioid treatment will have access to their treatment of choice on demand. Treatment on demand is defined as the individual meeting with a provider to initiate the treatment of choice on day one or day two of the request for treatment.

[33] LaBelle, C. T., Han, S. C., Bergeron, A., & Samet, J. H. (2015). Office-based opioid treatment with buprenorphine (OBOT-B): Statewide implementation of the Massachusetts collaborative care model in community health centers. *Journal of Substance Abuse Treatment, 60, 6-13.*

[34] Substance Abuse and Mental Health Services Administration (2009). Burprenorphine: A guide for nurses. Technical Assistance Publication Series (TAP 30)

Rationale:

- There are a range of substance use disorder treatment modalities, including detoxification/withdrawal management, outpatient therapy, residential treatment, and opioid agonist pharmacotherapy (also referred to as medication-assisted treatment or MAT). Not every individual experiencing opioid use disorder is interested in treatment with opioid agonist pharmacotherapy or is an appropriate recipient of MAT. Providing individuals seeking treatment with multiple treatment options supports the many pathways of recovery and respects client choice and autonomy.
- Research demonstrates racial/ethnic and socioeconomic disparities in service delivery.[35] Providing individuals seeking treatment with a comprehensive menu of treatment services removes barriers to treatment and promotes equity and social justice.
- Delays to treatment access can be life threatening. Every day an individual is waiting for treatment access, they are at risk of continuing to use heroin and/or opioids. For many, especially those experiencing opioid dependence, this means risk of overdose and death. Creating a system of care where treatment can be accessed rapidly reduces harm and ultimately save lives.
- According to the National Council for Behavioral Health, shorter wait periods are associated with fewer missed appointments, and strategies to reduce waiting times reduce no-show rates for appointments. Providing treatment on demand or "open access" to a comprehensive array of treatment services increases the likelihood of treatment engagement. Careful "open access" model development may also help to increase provider revenue and reduce costs.

Approach:

- Develop a plan and protocol for all outpatient behavioral health providers in King County to provide "open access" to services. "Open access" may include same-day access, walk in hours or days, next-day appointments or a combination of client-driven scheduling options. "Open access" strategies should ensure that timely, meaningful follow-up is provided to individuals seen for "open access" services or on-demand assessments. (See Attachment K for Implementation and Planning Details.)
- Assess treatment network adequacy on an ongoing basis to ensure all treatment modalities (including residential and detox beds) are available to achieve treatment on demand for King County residents. The philosophy of "treatment on demand" maintains that treatment capacity must be flexible and able to meet the fluctuating demand for services. Individuals experiencing opioid use disorder, clients of opioid treatment services, and advocacy groups like the People's Harm Reduction Alliance (PHRA) and Voices of Community Activists and Leaders (VOCAL) should be involved in identifying strategies for improving network adequacy and flexible access. (See Attachment K for Implementation and Planning Details.)

[35] Hansen, H. B., Siegel, C. E., Case, B. G., Bertollo, D. N., DiRocco, D., & Galanter, M. (2013). Variation in use of Buprenorphine and Methadone Treatment by Racial, Ethnic and Income Characteristics of Residential Social Areas in New York City. *The Journal of Behavioral Health Services & Research*, *40*(3): 367-377.

- Develop a plan to address the substance use disorder treatment workforce shortage and to support achievement of treatment on demand, timely and meaningful follow-up, and engagement of individuals seeking treatment. (See Attachment K for Implementation and Planning Details).
- Standardize and expand access to continuation of opioid treatment for incarcerated individuals in King County who are booked into jail and already stabilized on medication for treatment of opioid use disorder. Develop a plan to assist individuals incarcerated with untreated opioid use disorder, with direct referrals to a community-based MAT program upon release. (See Attachment K for Implementation and Planning Details).
- Develop and implement a plan for establishing and maintaining good neighbor relations. An example is provided of a neighbor relations plan that has been successfully implemented by a local opioid treatment program and has proven to be a very effective tool to fight stigma of clients served by opioid treatment programs and of treatment in general. (See Attachment L for Proposed Neighbor Relations Plan).

3. <u>Alleviate barriers placed upon opioid treatment programs, including the number of clients served and siting of clinics.</u>

Goal:

- King County will be able to provide readily accessible treatment to meet the needs of the community and will be able to rapidly adjust treatment capacity to ensure demand for services is met.

Rationale:

- Opioid treatment programs offering medication-assisted treatment (MAT) have been in existence since the 1960s. While opioid treatment programs have historically offered methadone treatment, they have recently been authorized to dispense buprenorphine as well. Opioid treatment programs are sanctioned by the federal government and Washington State as an effective way to treat withdrawal symptoms and relieve drug cravings from heroin and prescription opioid medications.[36] Research shows additional benefits include patients reduced or stopped use of injection drugs, a reduced risk of overdose and of acquiring or transmitting diseases, reduced criminal activity, and improved family stability and employment potential.[37] These benefits have also been demonstrated in Washington where MAT participation results in “lower health care costs” and “reduces arrests and convictions” for participants.[38]
- In 2014, opioid overdose deaths in King County were the highest ever recorded and remain high in 2015, with 229 opioid (heroin and/or pharmaceutical) overdose deaths

[36] University of Washington – Alcohol and Drug Abuse Institute – Medication Assisted Treatment for Opioid Use Disorders: Overview of the Evidence, June 2015, available at http://adai.uw.edu/pubs/infobriefs/MAT.pdf

[37] CDC – *Methadone Maintenance Treatment* – February 2002, available at http://www.nhts.net/media/Methadone%20Maintenance%20Treatment%20(20).pdf

38 DSHS Research and Data Analysis Division - *Methadone Treatment For Opiate Addiction Lowers HealthCare Costs And Reduces Arrests And Convictions* - June 2004 – https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-49.pdf

documented.[39] Buprenorphine and methadone maintenance treatment are evidence-based treatments for opioid use disorder that reduce overdose mortality by 50% compared to no treatment or treatment with therapy only.[40] Efforts to reduce barriers to providing effective opioid treatment for all individuals in need save lives.

- Stigmatization of people suffering from substance use disorder can impact policy regarding treatment. Despite the overwhelming evidence that MAT works, MAT service providers regularly face obstacles when trying to open new facilities. These hurdles include placement of barriers to finding suitable locations that comply with zoning regulations and obtaining operating permits from local jurisdictions. Alleviating unnecessary barriers to opioid treatment contributes to destigmatizing substance use disorders and overcoming prejudice and discrimination against people seeking treatment for substance use disorders.
- Approximately 5,000 individuals in King County may be interested in treatment for opioid use disorder (Caleb Banta-Green, University of Washington Alcohol and Drug Abuse Institute, personal communication, August 15, 2016). Efforts to alleviate barriers placed upon opioid treatment programs can expand access to treatment and address equity and social justice concerns created due to stigmatization of issues related to opioid use disorder.

Approach:

- Work to eliminate the Washington State cap on the number of clients permitted to be served at opioid treatment programs. Currently, opioid treatment programs are capped at 350 clients receiving opioid agonist pharmacotherapy per dispensary location, unless the county of residence provides a waiver. In King County, the Department of Community and Human Services, Behavioral Health and Recovery Division is authorized to provide this waiver, renewable annually. In order to meet local demand and provide treatment to a greater number of individuals in need, opioid treatment programs could provide additional services with extended hours. The Task Force is recommending changes to RCW 71.24.590 (Recodified from 70.96A.410) (Opiate substitution treatment – Program certification by department, department duties – Definition of opiate substitution treatment) to reduce barriers to treating individuals with opioid use disorder and expanding treatment capacity.
- Support a call to action for community collaboration in establishing opioid treatment programs and associated supportive and/or complimentary services. State law is intended to allow for the operation of MAT facilities. One of the main obstacles to opening MAT facilities results from the actions of local governments, generally via permitting and zoning regulations. But they are counterproductive in combatting the opioid epidemic and generally grounded in a lack of knowledge about how these programs operate and how the facilities will impact the surrounding areas. To combat these misperceptions, there is a great need for sharing information about the vital

[39] Drug Abuse Trends in the Seattle-King County Area: 2015. Banta-Green, C et al. Alcohol & Drug Abuse Institute, Univ. of Washington, July 2016. http://adai.uw.edu/pubs/pdf/2015drugusetrends.pdf

[40] Pierce, M., Bird, S. M., Hickman, M., Marsden, J., Dunn, G., Jones, A., *and* Millar, T. (2016) Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. *Addiction,* 111: 298–308.

importance of these facilities and their social and health benefits and to use evidence to address public safety concerns. A public education campaign and the support of elected officials could greatly expedite getting more MAT facilities up and running in a short amount of time. (See Attachment M for Implementation and Planning Details.)

- Work to amend RCW 71.24.585 (Recodified from 70.96A.400) (Opiate substitution treatment – Declaration of regulation by state) to reflect the potential need for long-term MAT as a current standard of care for effective treatment of opioid use disorder. Current language declares the primary goal of opioid substitution treatment is to "eliminate substance use, including opioid and opiate substitute addiction of program participants" and suggests a small percentage of persons who participate in opioid substitution treatment programs require treatment for an extended period of time. This is inconsistent with current evidence-based best practice guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA recommends a phased approach to treatment involving medication maintenance and consideration of individual need when determining whether to discontinue opioid agonist pharmacotherapy or pursue long-term maintenance.[41] The Office of National Drug Control Policy suggests "ongoing MAT may be the safest and best approach for opiate rehabilitation" due to research demonstrating opiate agonist pharmacotherapy is associated with reduced risk of relapse and overdose relative to treatment with psychosocial services alone.[42]

User Health Services and Overdose Prevention Recommendations

1. <u>Expand distribution of naloxone in King County, Washington.</u>

Goals:

- Reduce drug related overdose deaths by expanding the distribution of naloxone to individuals using heroin and pharmaceutical opioids, their social networks, and professionals who may administer naloxone through the course of their work.
- Educate service providers and the community about naloxone availability and access points, and inform the public about the Good Samaritan 911 Overdose Law.

Rationale:

- Naloxone is an opioid overdose antidote that may be safely used by health professionals and laypersons. When prioritizing interventions, the risks of the opioids being used, the likelihood of the naloxone recipient having or witnessing an overdose, and the overdose risks related to the location/timing of naloxone distribution should all be considered.

[41] Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 43.) Available at http://www.ncbi.nlm.nih.gov/books/NBK64164

[42] The White House, Office of National Drug Control Policy. (2012). *Medication-Assisted Treatment for Opioid Addiction* [Health Brief]. Retrieved from https://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf

- Evidence exists for distributing naloxone to heroin users and their social networks at syringe exchanges. Adequate evidence does not currently exist for other means of distributing or administering naloxone. Given the limited financial resources, as well as the limited opportunities to work with stakeholders and the public on issues related to opioid use disorder and overdose, it is important to consider interventions that are most likely to have a public health impact by preventing and reversing the greatest number of overdoses. Outcomes may also be positively impacted by increasing awareness of overdose prevention, overdose recognition, and overdose response including rescue breathing and the Good Samaritan Overdose law. (See Attachment N for Naloxone Distribution and Administration Bibliography.)

Approach:

- Expand distribution of take-home naloxone to individuals using heroin and pharmaceutical opioids and their social networks.

  Syringe exchanges
  - Expand programs for take-home-naloxone at syringe exchanges so that it is free and available to all who want it.
  - Consider dispensing more than one naloxone kit per client so that they can further distribute naloxone in their social networks.

  Jail
  - Expand naloxone distribution services to all correctional facilities in King County. Funding for staffing and other resources will need to be determined.

  Pharmacies
  - Request that insurers provide adequate reimbursement of take-home naloxone so that pharmacies will be willing to stock, prescribe and dispense naloxone.
  - Advocate with insurers, as well as state regulators and policy makers as appropriate, for coverage/reimbursement of take-home-naloxone for persons not at risk for overdose but who are household members or other close contacts of persons who are at risk for opioid overdose.
  - Incorporate education about naloxone availability at pharmacies in educational campaigns.
  - Encourage pharmacies to educate individuals at risk for opioid overdose regarding overdose prevention and treatment and to consider obtaining take-home naloxone.

  Prescribers
  - Encourage prescribing of take-home naloxone to those at elevated risk for overdose due to their prescribed opioid use.. Targeting diverse care settings is appropriate, including emergency departments, primary care, specialty care, behavioral health, and withdrawal management facilities.

- Explore ways to more easily dispense naloxone directly to individuals in emergency departments, rather than requiring patients to take a prescription to a pharmacy.

Outreach workers

- Explore options for outreach workers to distribute take-home naloxone to those not accessing it through other services such as syringe exchange.

- Evaluate police/fire/Emergency Medical Services (EMS)/social/health services staff/schools having naloxone for administration in the course of their work.

Police and Fire

- Evaluate the utilization and health impacts of naloxone administered by police and emergency medical technicians.

Paramedics

- Develop and implement procedures to document opioid overdose occurrence.
- Develop and implement procedures to document bystander responses to opioid overdoses.

Social/Housing/Health Services staff

- Expand overdose education and naloxone availability for staff at facilities where opioid overdoses are likely to occur.
- Evaluate the utilization and health impacts of naloxone administered by social/housing/health services staff.

- Educate the public about opioid use disorder and the Good Samaritan 911 Overdose Law.
  - Incorporate education about the Good Samaritan overdose 911 law into public education about opioid use disorder and overdose.
  - Educate school staff about opioid use disorder and overdose risk as well as the Good Samaritan overdose law so they can provide appropriate education, referrals and interventions.

- Implement systematic and consistent ways to document naloxone distribution, utilization and disposition.
  - Encourage agencies and programs distributing and administering take-home-naloxone to collect standardized data at the time of distribution (E.g., demographics, motivation for obtaining naloxone, opioid use) and when obtaining a refill (disposition of the naloxone and health impacts of naloxone administration).

- Improve communication among stakeholders about practices and protocols related to naloxone distribution.

- Encourage stakeholders to meet to proactively discuss current naloxone distribution and administration practices and protocols to ensure coordination, consistency, clarity and good health outcomes.

2. **Establish, on a pilot program basis, at least two Community Health Engagement Locations* (CHEL sites) where supervised consumption occurs for adults with substance use disorders in the Seattle and King County region. One site should be located outside of Seattle, reflecting the geographic distribution of drug use in other King County areas. The CHEL pilot program should have a provisional time limit of three years. Continuation of the program beyond that time should be based on evidence of positive outcomes.**

   * The Task Force will refer to sites that provide harm reduction services where supervised consumption occurs as Community Health Engagement Locations for individuals with substance use disorders (CHEL sites). This terminology recognizes that the primary purpose of these sites is to engage individuals experiencing opioid use disorder using multiple strategies to reduce harm and promote health, including, but not limited to, overdose prevention through promoting safe consumption of substances and treatment of overdose. The Task Force's equity and social justice (ESJ) charge emphases the importance of providing support and services to the most marginalized individuals in the County experiencing substance use disorders. The Task Force asserts that the designation CHEL sites is a non-stigmatizing term that recognizes that these sites provide multiple health interventions to decrease risks associated with substance use disorder and promote improved health outcomes.

   Goals:
   - Reduce drug-related health risks and harms including overdose death, transmission of HIV and hepatitis B and C viruses, and other drug-associated adverse health effects.
   - Provide access to substance use disorder treatment and related health and social services, provide a safe and trusting environment where people who use drugs can engage with services to improve their health and reduce criminal justice system involvement and reduce emergency medical services utilization.
   - Improve public safety and the community environment by reducing public drug use and discarding of drug using equipment.

   Rationale:
   - CHEL sites (aka supervised or safe consumption sites in other jurisdictions) offer a supervised place for hygienic consumption of drugs in a non-judgmental environment free from stigma, while providing low-barrier access to on-site health services and screenings, referrals, and linkages to behavioral health and other supportive services (for example, housing).
   - Supervised consumption sites (SCS) have been operating in Europe since 1988. Sites in Sydney, Australia, and Vancouver, Canada, began operating in 2001 and 2003, respectively. As of 2014, there are 90 SCSs operating across the globe on three continents. (See Attachment O for Community Health Engagement Location [aka

Supervised Consumption Site] Bibliography, and see Attachment P for World Overview of Supervised Consumption Sites.)

- Published evaluations from existing SCSs show that SCSs can reduce overdose deaths and behaviors that cause HIV and hepatitis C infection (such as sharing of injection equipment and supplies), reduce unsafe injection practices, increase use of detox and substance use disorder treatment services, reduce public drug use and the amounts of publically discarded injection equipment; and, do not increase drug use, crime, or other negative impacts in the area of the SCS. SCSs can also be cost-effective. (See Attachment O for Community Health Engagement Location [aka Supervised Consumption Site] Bibliography.)
- SCSs are intended to engage individuals in substance use disorder treatment and other supportive services (physical and behavioral health care, housing, social services) who may not engage in traditional treatment related to substance use. The King County Board of Health previously endorsed and adopted the HIV/AIDS Committee's 2007 strategic and operational plan for HIV prevention in King County that included a recommendation to promote the use of a "safe injection site" within King County. (See Attachment O for Community Health Engagement Location [aka Supervised Consumption Site] Bibliography.)
- In July, 2016 the City Council of Toronto, Canada, approved the implementation of three SCSs for the downtown area of Toronto. In their decision making process, the City Council of Toronto considered data published in the 2012 Report of the Toronto and Ottawa Supervised Consumption Assessment Study (TOSCA), funded by the Ontario HIV Treatment Network and the Canadian Institutes of Health Research, and the Supervised Injection Services Toolkit prepared by the Toronto Drug Strategy Implementation Panel in 2013. (See Attachment O for Community Health Engagement Location [aka Supervised Consumption Site] Bibliography.)
- Published studies support the effectiveness of the services provided at SCSs in reducing drug-related health risks and overdose mortality for individuals utilizing the SCSs. Research of established SCSs also did not reveal an increase in criminal activity or negative impacts on the communities following the implementation of SCSs in those areas.

Approach:

- Evaluation
  The Taskforce recommends a rigorous evaluation process be integrated into the planning and design of the CHEL program. Outcomes should include fatal overdose prevention, other health outcomes, community and environmental indicators (impact on public drug use/injection, community impact including neighborhood perceptions and public safety experiences, OD-related first responder calls, 911 calls, etc.), and impact of linkage to services. Evaluation should be performed by public agencies (Public Health – Seattle & King County and King County Department of Community Health Services) and/or by third-party evaluators. Potential third party evaluators include the University of Washington School of Public Health, the Alcohol and Drug Abuse Institute (ADAI), the Harm Reduction Research and Treatment Center (HaRRT), Cardea, and Battelle. To the

extent feasible, selected indicators should be monitored in near real time in order to inform the need for any change in these recommendations during the pilot period.

- Planning and Implementation
  - Continue to engage members of the community (including civic and business stakeholders) and potential CHEL clients to inform the planning and implementation process and ensure the environment and services provided adequately and appropriately address the needs of the clients and the surrounding community.
  - Community partners and stakeholders (including persons who use drugs) should continue to be engaged in the CHEL planning and implementation process throughout the duration of the pilot program.
  - Conduct an Equity Impact Review in the planning process prior to implementation: http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/2016/The_Equity_Impact_Review_checklist_Mar2016.ashx?la=en

- Sponsorship
  - Proposed CHEL program sponsorship options may include:
    - Public Health – Seattle & King County (PHSKC) in collaboration with King County Department of Community and Human Services (DCHS), or;
    - A public-private partnership between PHSKC/DCHS and other community-based service providers, or;
    - Another entity with oversight by PHSKC/DCHS.
  - See Attachment Q for Legal Framework Grid, and see Attachment R for Summary of Legal Considerations for CHEL sites in King County

- Siting
  - Consideration for siting CHELs should include the following priorities:
    - Geographic concentration of drug consumption and overdose.
    - Co-location with or in close geographic proximity to (if co-location not possible) existing services utilized by the target population.
    - Local governmental and community engagement.
    - Fixed locations are preferred over a mobile CHEL during the pilot period
    - Establish at least one site outside the city of Seattle.
  - Geographic areas that have been identified as drug use/OD “hotspots”, and that could potentially benefit from the services provided by a CHEL, should be prioritized for potential CHEL sites.

- Services Provided at a CHEL
  - The following services should be provided (essential services):
    - Hygienic space and sterile supplies
    - Overdose treatment: naloxone and oxygen administration
    - Overdose prevention: naloxone kit distribution
    - Syringe exchange services
    - Sexual health resources and supplies (including male and female condoms)
    - Drinking water; restrooms
    - Direct provision of (preferred), or linkage to, basic medical treatment (wound care), wraparound social services and case management
    - Peer support
    - Health education

    - Rapid linkage to medication-assisted treatment, detox services and outpatient/inpatient treatment services
    - Security and crisis response plan
    - Post-consumption observation space
    - Every effort is to be made to ensure that the provision of supplies and space for consuming illicit drugs (NOT tobacco-containing products or marijuana) via smoking (more precisely sublimation, meaning without combustion of the drug itself) and nasal inhalation be incorporated into the CHEL program design.
  - The following services are highly desirable (but not essential):
    - On site medication-assisted treatment (MAT, for example, buprenorphine treatment)
    - On site drug and alcohol assessment
    - Basic medical treatment and screening services
    - Linkage to legal services

- Staffing
  - CHEL staffing should include at minimum: one (1) licensed healthcare professional (for example registered nurse) and appropriate support staff for the size of facility and scope of services provided, such as social workers, peer support workers, site manager(s) and/or security workers.
  - Medical supervision by a licensed healthcare professional should be provided on site during all hours of operation.

- Funding

  No current dedicated resources have been identified to support CHEL implementation and evaluation. Possible public and private resources for this purpose should be explored during the recommendation implementation phase.

- Partner Service Providers
  - A CHEL should be an integrated part of the wide array of services and programs available to the target population. The pilot program should work in close cooperation with:
    - Drug treatment services
    - Medical and behavioral healthcare services including primary health care providers
    - Social services case management
    - Housing assistance
    - Employment assistance
    - Legal Services
    - EMS
    - Law enforcement

VI. Prioritization

The King County Heroin and Prescription Opiate Addiction Task Force proposes that its recommendations be considered and prioritized based on the following factors:

- Evidence base for effectiveness
- Population health/safety impact
- Community support
- Equity
- Complexity/Feasibility
- Legal considerations
- Cost
- Sustainability

Each of these factors is described in further detail below.

Evidence base for effectiveness: To what extent are there published studies or other data supporting the intervention for the population of interest? How rigorous was the research (for example, was there a comparison group? What conflicts of interest did the researchers have?). How big was the intervention effect compared to those who didn't receive the intervention? Is there statistical significance in the findings within relatively small confidence intervals (in other words, how likely is it that the results are the result of the intervention, and not chance)? Have the results been replicated? Do published studies include sub-group members that are demographically distinct by race, age, gender, etc.? What do experts in the field say about the intervention?

Population health/safety impact: How many people would potentially benefit from the intervention? What is the magnitude of the health impact for individuals? What results do we expect to see on specific groups of people in the target community or on the community as a whole? Populations may be geographic and/or identity driven. Examples include all the residents of King County, all 18-25 year olds, all individuals with an incarceration history, and all people living below 200% of the federal poverty level in south King County.

Community support: What is known about community support or opposition within the geographic area where the recommendation is likely to be implemented, or among the stakeholders that would be involved in the recommendation's implementation? Have community meetings been held and focus groups conducted? What kinds of statements for or against have appeared on print and social media sites? Are there any community-initiated initiatives occurring that support or oppose the intervention? Are there strategies to address community and stakeholder concern?

Equity: To what extent and in what ways will the proposed recommendation mitigate or exacerbate existing population inequities or create new ones? Who would be most affected by the change in equity?

Complexity/Feasibility: How difficult would it be to implement the recommendation? What is required for implementation? How long would it take to get the recommendation off the ground? How many entities need to be engaged and in agreement to implement?

Cost: What will it cost to implement the recommendation? What costs are absolute and what may be incremental? How will the intervention be funded? Are there alternatives to how a strategy might be implemented that would affect cost (for example, number of facilities, program size, staffing levels, size of target population, etc.)?

Legal considerations: Is the recommendation allowable under existing federal/state/local law? What dispensations, if any, are needed from law enforcement or other entities? What types and levels of difficulties and/or risk can be anticipated due to legal issues (for example, insurance purchase, client harassment, law enforcement action)? What legislative or regulatory change would be required, at what level of government?

Sustainability: What potential funding sources and mechanisms exist to support the recommended interventions in future years (if continuation is desired)? How likely are these sources to be obtained? What commitments have been secured to sustain recommendations?

The factors above should be considered when determining when and how to implement the recommendations developed by the Task Force. All recommendations developed by the Task Force are intended to significantly positively influence public health outcomes and community welfare.

VII. Draft Evaluation Plan

It is essential to understand what impact interventions implemented in accordance with the King County Heroin and Prescription Opiate Addiction Task Force recommendations have on the target population and the community. Evaluation results can be used to make policy and practice decisions about whether to modify or continue interventions. The initial draft evaluation plan maps each of the key outcomes of interest to one or more of the Task Force's three areas of focus: primary prevention, treatment, and health services for individuals experiencing opioid use disorder. There are eight outcomes of interest and specific measures for each outcome:

Outcome of Interest	Outcome Measures
Survival	• Overdose mortality • Other drug-related mortality (acute and chronic)
Infectious Diseases	• HIV diagnoses, HIV transmission risk among HIV-infected PWID, hepatitis C diagnoses, hepatitis C treatment, hepatitis C cure
Health Indicators	• Non-fatal overdose, skin and soft tissue infections, cardiovascular outcomes, quality of life

Drug Use	• Prevalence of drug use and injection (by type of drug), syringe and other injection equipment sharing, unsafe injection practices, transition to safer injection and other use practices
Drug Treatment and Health Care	• Enrolled and maintained on buprenorphine treatment, enrolled and maintained on methadone treatment, EMS/ER use, enrollment in health insurance, has primary care provider
Community Impact and public safety	• Syringes and paraphernalia around CHEL, drug-related arrests, 911 calls - number and types, public injection, property values
Community Health Engagement Location (CHEL)	• Number of clients, number of encounters, overdoses on site, overdoses reversed on site, client satisfaction, feasibility and sustainability
Implementation of Prevention Efforts	• Education materials created and the number distributed, secure medication return implemented and accompanying messaging implemented, existing screening efforts augmented to include opioid misuse and opioid use disorder

The evaluation plan includes monitoring the impact of the intervention(s) at both the population and individual levels. In other words, these analyses would allow stakeholders to understand how interventions impact the general population (for example, did opioid overdose mortality rates in King County decline after an intervention was introduced?) as well as how interventions impact individual people (for example, is someone who gets maintained on buprenorphine less likely to have an opioid overdose?).

The evaluation plan proposes analyses of multiple existing data sources and the establishment of a cohort study that follows people who use drugs over time. Examples of existing data sources that will be queried include: vital statistics, administrative claims data, medical records, HIV and HCV surveillance data, needle exchange survey, and program utilization data. The cohort study will enroll individuals using drugs – some, but not all, of whom will seek services related to the new interventions – and collect baseline and follow-up data, which allow for service uptake patterns and rates to be measured and for the relationship between service uptake and health outcomes to be assessed. The cohort study design will capture outcomes that are most likely to be impacted by the proposed interventions but difficult to measure using existing data sources, including: syringe sharing, public injection, skin and soft tissue infections, and quality of life indicators.

Some of these secondary analyses are already being conducted within the University of Washington's Alcohol and Drug Abuse Institute (ADAI) in collaboration with King County's Departments of Community and Human Services and Public Health. However, the proposed evaluation would greatly exceed current FTE capacity and require additional funding, staffing, and new collaborations. Based on the evaluation plan described above, additional resources will require one full time employee (FTE) to lead the secondary data analyses, including analyses to establish baseline metrics for key outcomes.

VIII. Current Local and National Activities

In light of the increased prevalence of heroin as a drug of abuse and associated substantial morbidity and mortality, the Task Force was directed to confront the heroin and opioid addiction epidemic with immediate action in King County. To respond to this directive, whenever possible, the Task Force initiated immediate implementation of promising and/or evidence-based interventions rather than postponing implementation for presentation of the recommendations to the Task Force sponsors. Current status of local efforts to enhance primary prevention, opioid treatment and the health of individuals with opioid use disorder is described below. The Task Force also provided support to relevant state and federal initiatives and projects that would positively impact local efforts to address the opioid challenge. These state and federal initiatives are also described below.

Primary Prevention: Current Local Efforts

- The Task Force is partnering with organizations and entities developing countywide safe prescription drug disposal programs. The City of Seattle enacted a resolution expressing support for an effective, countywide disposal program for prescription drugs and controlled substances, and requesting local pharmacies and the Seattle Police Department install drug disposal drop-boxes across the city. Additionally, the King County Hazardous Waste Management Program is developing a safe disposal program (also known as a secure medicine return program) throughout the County; the Task Force will partner in this effort to publicize and promote the availability of secure medicine return sites. Finally, the Washington State Hospital Association has teamed up with a toxicology company to collect unused prescription drugs and safely dispose of them.
- The University of Washington Alcohol and Drug Abuse Institute (ADAI), represented on the Task Force, will host a state Department of Health nurse consultant to provide education and training, including tele-health sessions, on opioid addiction for professionals and community members.

Treatment Expansion and Enhancement: Current Local Efforts

- The Task Force is developing a strategy for expanding access to buprenorphine treatment by increasing the number of access points for receiving buprenorphine induction, stabilization and maintenance services in King County. The Downtown Public Health Needle Exchange and Public Health – Seattle & King County Mobile Medical Van are currently designing plans for low barrier implementation of buprenorphine services through pilot programs, effective in the fourth quarter of 2016. The pilot program at the needle exchange will pilot a “bupe first” model that focuses on medication stabilization as the primary goal of treatment. Other proposals for expanded access through community health clinics, emergency departments, behavioral health clinics (including traditional medication-assisted treatment [MAT] facilities), and local jails, have been developed and critical resource needs have been identified. The Department of Public Health – Seattle & King County Jail Health Services is currently evaluating the number of

individuals booked into the King County jail who are stable on buprenorphine to determine the feasibility of providing buprenorphine maintenance services during incarceration. The ultimate goal is to evaluate demand for both induction and maintenance services and devise a plan to provide these services to individuals with opioid use disorder who desire MAT.

- The Task Force conducted GIS mapping of current service sites (opioid treatment programs, behavioral health treatment agencies, needle exchange facilities, public health clinics, emergency departments, and hospitals) to evaluate network adequacy and geographic accessibility. The service map can be found at the following location: http://kingcounty.maps.arcgis.com/apps/webappviewer/index.html?id=d9424b892f404c39a07cda52390ce627. The Recovery Help Line is currently developing a plan for how King County could achieve centralized access and referral to treatment services in order to facilitate treatment on demand.
- In 2015, King County conducted a survey of behavioral health provider agencies to learn about recruitment and retention issues. Position vacancies were high and low wages relative to other professional opportunities significantly contributed to staff retention challenges. The King County Department of Community and Human Services, Behavioral Health and Recovery Division is designing a plan to address the workforce shortage in order to promote network adequacy and support achievement of treatment on demand.
- The Task Force has analyzed the challenge presented by local jurisdictions that make it difficult for opioid treatment providers to open treatment facilities. A legal analysis has been drafted describing the legality of MAT program facilities in Washington, common challenges in opening MAT facilities, and options to ease restrictions on opening MAT facilities. Additionally, the Task Force is drafting proposed amendments to state legislation that is inconsistent with the current standard of care for treatment of opioid use disorder and poses unnecessary barriers to treatment access (RCW 71.24.585 and RCW 71.24.590, respectively).
- The King County Department of Community and Human Services' Behavioral Health and Recovery Division, Washington State Health Care Authority (HCA) and Medicaid Managed Care Organizations (MCOs) convened in June and August 2016 to discuss the collaborative care/nurse care manager model as a means of supporting expansion of buprenorphine services for treatment of opioid use disorder. System barriers and funding challenges were identified. The group is currently working on developing a plan to support implementation of a collaborative care/nurse care manager model to facilitate buprenorphine services delivery in King County.

User Health and Overdose Prevention: Current Local Efforts

- Naloxone distribution is being expanded to ensure easy access to overdose prevention with distribution efforts that involve many providers, first responders and locations throughout the County. The County Department of Community and Human Services, Behavioral Health and Recovery Division is partnering with Kelley-Ross pharmacy to distribute naloxone to persons identified in the publicly funded treatment system. Additionally, naloxone is now being distributed through 18 homeless housing providers

for use in housing settings, and participating housing partners have documented two overdose reversals prior to the date of this report. DCHS has also distributed naloxone kits to local law enforcement including the Sheriff's Office and the Kent, Auburn and Redmond police departments and overdose reversals have also occurred as the result of this project. The Marah Project has collaborated with the Seattle Police Department and the UW Alcohol and Drug Abuse Institute (ADAI) to distribute naloxone to police officers on bicycles and evaluate implementation. As of August, 2016, 10 administrations of naloxone had been documented as a result of this collaboration. Finally, planning is underway for the King County Emergency Medical Services to develop an emergency medical technician naloxone program for County agencies; implementation of a pilot program is slated for the fall of 2016. All of the entities noted above (DCHS; pharmacy; housing providers; law enforcement; first responders; Marah Project; ADAI; city of Seattle; and Sound Cities Association) are represented on the Task Force. From the time the Task Force started until August 15, 2016 there have been at least 14 documented naloxone administrations to people in an overdose state as a result of the efforts from Task Force members.

State and Federal Initiatives

- The Comprehensive Addiction and Recovery Act (CARA) was approved by Congress and signed by the President on July 22, 2016. This legislation treats addiction as a disease and prioritizes prevention, treatment and recovery support services for those living with, and in recovery from, substance use disorders. The Act modifies the qualifications for providers who may prescribe buprenorphine to include nurse practitioners and/or physician assistants who meet specific licensing and training requirements. Additionally, it expands federal funding for opioid reversal medications and drug disposal sites, among other appropriations. (See Attachment S for Key Potential Opportunities for Washington and King County in CARA.)
- The Centers for Disease Control and Prevention issued Guidelines for Prescribing Opiates for Chronic Pain that provides recommendations for safer and more effective prescribing of opioids for adults in outpatient settings.
- In response to President Obama's call for the federal government to identify barriers to treatment for opioid use disorders, the Centers for Medicare and Medicaid Services (CMS) will require Medicare Part D formularies to allow access to medication-assisted treatment for these disorders.
- In the spring of 2016, the White House announced the final proposed Health and Human Services rules that mandated that doctor caps for prescribing buprenorphine were to be raised to 275 individuals per each Drug Addiction Treatment Act waivered physician. The Task Force submitted comments urging the implementation of these rule changes which were promulgated in final form effective August 8, 2016.
- In 2013 the federal Substance Abuse and Mental Health Services Administration (SAMHSA) provided its final rule giving opioid treatment programs (OTPs) the flexibility to dispense buprenorphine take-homes, with no predetermined waiting period for individuals who are stable. In June of 2016 the State of Washington confirmed the use of

medications other than methadone that can be utilized in OTPs, including buprenorphine/naloxone (Suboxone®) and naloxone.

- In August, 2016 the U.S. Surgeon General, Dr. Vivek Murthy, announced his Turn the Tide Rx movement. Dr. Murthy is calling on health care professionals across the nation to take a pledge to educate themselves to treat pain safely and effectively, screen individuals for opioid use disorder and provide or connect individuals with evidence-based treatment, and talk about and treat addiction as a chronic illness, not a moral failing.
- The Department of Health, Washington State Department of Social and Health Services, Washington State Department of Labor and Industries, Washington State Health Care Authority, and University of Washington Alcohol and Drug Abuse Institute have created a statewide Interagency Opioid Working Plan that outlines a strategy for addressing the opioid abuse and overdose crisis. Priority goals include enhancing primary prevention; treatment of opioid use disorder, overdose prevention, and data collection (for the purposes of evaluating interventions, monitoring morbidity/mortality, and detecting misuse). Priority actions include improving prescribing practices, expanding treatment access, distributing naloxone to those using heroin, and optimizing and expanding data sources. Workgroups have been created to oversee implementation of strategies designed to address the four identified goals.

IX. Next Steps

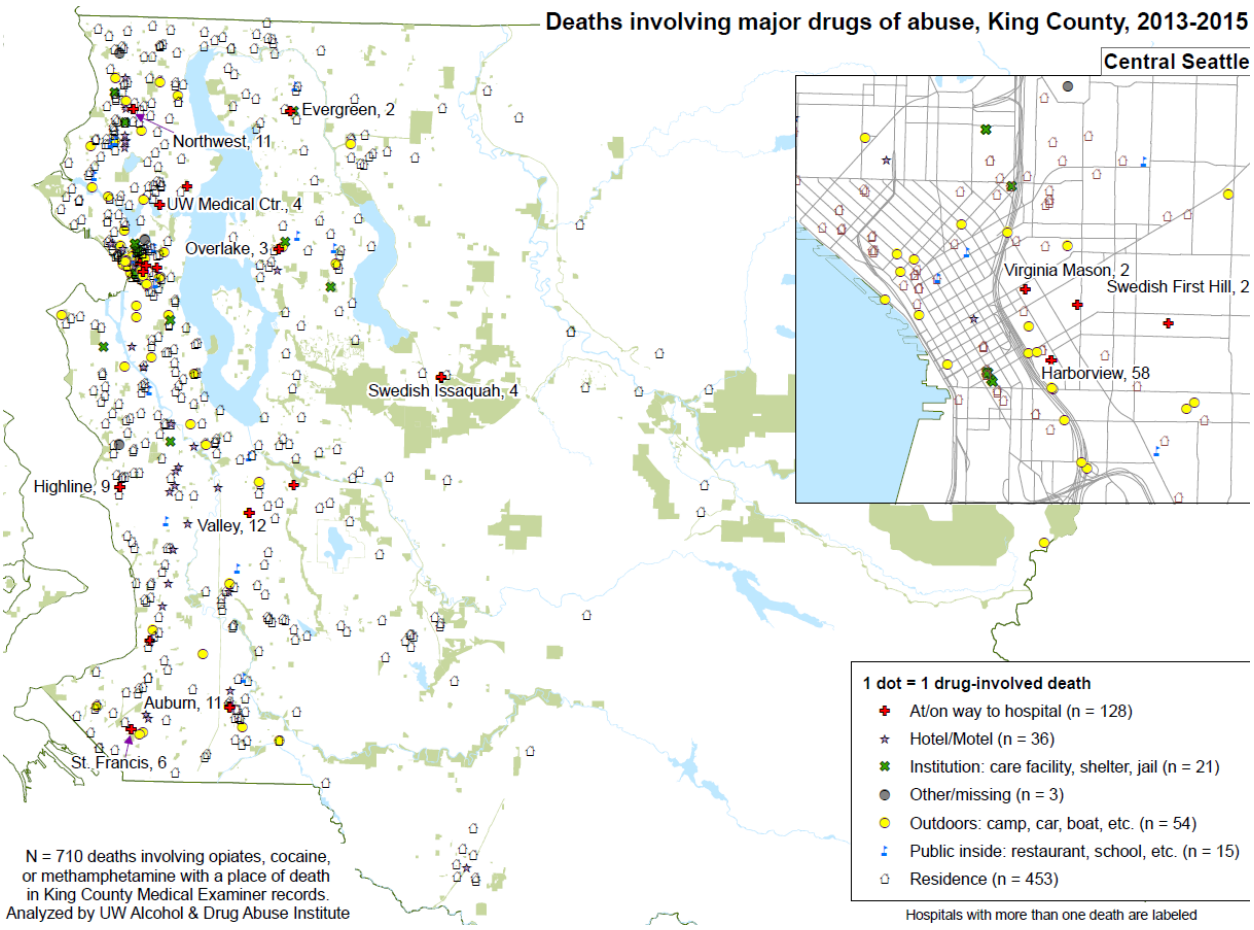
The Heroin and Prescription Opiate Addiction Task Force recommends that local government and other partners begin to implement the recommendations contained in the report as soon as possible. As previously noted, the Task Force has already begun to implement some recommendations with existing resources and the support of the County. Other recommendations have not yet been implemented.

The Task Force recommends that existing Task Force workgroups continue to convene, and that these can potentially transition to oversight groups to help guide implementation of the Task Force's recommendations.

After review of this report by the Task Force sponsors, implementation teams should be assembled corresponding to the various recommendations. It may also be useful to assemble special teams or work groups to help identify resources for implementation of the recommendations and to assist with public education and communication.

The Task Force requests that within 90 days of receipt of this report the sponsors provide a formal response to the recommendations in the report, and that the Task Force reconvene at that time to assess the response. The Task Force should also reconvene as needed to help facilitate and/or evaluate implementation of the recommendations, including at three to five years to review progress made and associated outcomes, and to recommend what, if any, further action should be taken to address the challenge of opioid abuse in King County.

Attachment A
MAP OF OVERDOSE DEATHS IN KING COUNTY, 2013-2015



Attachment B
HEROIN AND PRESCRIPTION OPIATE ADDICTION TASK FORCE MEMBERS

Task Force Member	Agency/Entity	Voting Member
Brad Finegood	King County Department of Community and Human Services	No
Jeff Duchin	Public Health - Seattle & King County	No
Caleb Banta-Green	University of Washington Alcohol and Drug Abuse Institute	Yes
Kate Joncas	City of Seattle Mayor's Office	No
Scott Lindsay	City of Seattle Mayor's Office	No
Jim Pugel	King County Sheriff's Office	Yes
Robert Merner	Seattle Police Department	No
Frank Chafee	Public Health - Seattle & King County	No
Karen Hartfield	Public Health - Seattle & King County	No
Reba Gonzales	Seattle Fire Department	No
Tom Rea	King County EMS	No
Catherine Lester	Seattle Human Services Department	No
Jeff Sakuma	Seattle Human Services Department	No
Darcy Jaffe	Harborview Medical Center	Yes
Mark Larson	King County Prosecuting Attorney's Office	Yes
Mark Cooke	American Civil Liberties Union (ACLU)	Yes
Steve Stocker	Auburn Police Department	Yes
Kevin Milosevich	Renton Police Department	Yes
Tim Bondurant	Veteran's Administration	Yes
Jim Walsh	Swedish Hospital, Pregnant and Parenting Women Program	Yes
Charissa Fotinos	Washington State Department of Social and Health Services, Behavioral Health Administration and Health Care Authority	Yes
Lisa Daugaard	Public Defender Association	Yes
Patricia Sully	Public Defender Association	Yes
Annette Hayes	U.S. Attorney for the Western District of Washington	No
Penny Legate	The Marah Project	Yes
Thea Oliphant-Wells	King County Needle Exchange	No
Mark Putnam	All Home	No

Task Force Member	Agency/Entity	Voting Member
Dan Cable	Muckleshoot Tribe	Yes
Molly Carney	Evergreen Treatment Services	Yes
Norm Johnson	Therapeutic Health Services	Yes
Michael Ninburg	Hepatitis Education Project	Yes
Andy Adolfson	City of Bellevue Fire Department	Yes
Pegi McEvoy	Seattle Public Schools	Yes
Shilo Murphy	People's Harm Reduction Alliance (PHRA)	Yes
David Dickinson	U.S. Substance Abuse and Mental Health Services Administration, Regional Office	Yes
Roger Dowdy	Neighborcare	Yes
Annie Hetzel	Puget Sound Educational Service District	Yes
Mary Taylor	King County Drug Court	Yes
Daniel Malone	Downtown Emergency Service Center	Yes
Ryan Oftebro	Kelley-Ross Pharmacy	Yes
Suzan Mazor	Seattle Children's	Yes
Milena Stott	Valley Cities Behavioral Health	Yes
Natalie Green	Department of Social and Health Services Children's Admin.	Yes

STAFF:

- Chelsea Baylen – King County Department of Community and Human Services
- Steve Gustaveson – King County Department of Community and Human Services
- Marcee Kerr – Public Health – Seattle & King County
- Milena Stott – Valley Cities Behavioral Health
- Erin James – King County Department of Community and Human Services

Attachment C
HEROIN AND OPIATE ADDICTION WORKGROUPS

Primary Prevention Workgroup

Member	Agency/Entity
Caleb Banta-Green	University of Washington Alcohol and Drug Abuse Institute
Pegi McEvoy	Seattle Public Schools
Suzan Mazor	Seattle Children's
Penny Legate	The Marah Project
Charissa Fotinos	Washington State Department of Social and Health Services, Behavioral Health Administration and Health Care Authority
Kevin Milosevich	Renton Police Department
Andy Adolfson	City of Bellevue Fire Department
Robert Merner	Seattle Police Department
David Dickinson	U.S. Substance Abuse and Mental Health Services Administration, Regional Office
Annie Hetzel	Puget Sound Educational Service District
Jeff Sakuma	Seattle Human Services Department
Natalie Green	Department of Social and Health Services Children's Administration
Milena Stott	Valley Cities Behavioral Health
Erin James	King County Department Community and Human Services

Treatment Expansion and Enhancement Workgroup

Member	Agency/Entity
Brad Finegood	King County Department Community and Human Services
Dan Cable	Muckleshoot Tribe
Molly Carney	Evergreen Treatment Services
Norm Johnson	Therapeutic Health Services
Daniel Malone	Downtown Emergency Service Center
Mary Taylor	King County Dept. of Judicial Administration
Roland Akers	Community Member
Roger Dowdy	Neighborcare
Darcy Jaffe	Harborview Medical Center
Tim Bondurant	US Veterans Administration
Tom Rea	King County Emergency Medical Services
Mark Larson	King County Prosecuting Attorneys' Office
Jim Walsh	Swedish Hospital, Pregnant and Parenting Women's Program
Lisa Daugaard	King County Public Defender Association
Jeff Sakuma	Seattle Human Services Department
Shilo Murphy	People's Harm Reduction Alliance
Laurie Sylla	King County Department Community and Human Services
Kris Nyrop	King County Public Defender Association
Cynthia Hobbs	Therapeutic Health Services
Milena Stott	Valley Cities
Caleb Banta-Green	University of Washington Alcohol and Drug Abuse Institute
Chelsea Baylen	King County Department Community and Human Services

User Health Services and Overdose Prevention Workgroup

Member	Agency/Entity
Jeff Duchin	Public Health - Seattle & King County
Mark Cooke	American Civil Liberties Union (ACLU)
Lisa Daugaard	Public Defender Association
Annie Hetzel	Puget Sound Educational Service District
Brad Finegood	King County Department of Community and Human Services
Shireesha Dhanireddy	University of Washington/Harborview Medical Center
Chloe Gale	REACH Program
Charissa Fotinos	Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR)
Reba Gonzales	Seattle Fire Department
Annette Hayes	U.S. Attorney for the Western District of Washington
Karen Hartfield	Public Health - Seattle & King County
Scott Lindsay	City of Seattle Mayor's Office
Joe Tinsley	King County Needle Exchange
Dan Otter	UW Public Health
Kris Nyrop	Public Defender Association
Patricia Sully	Public Defender Association
Mark Putnam	All Home
Michael Ninburg	Hepatitis Education Project
Ryan Oftebro	Kelley-Ross Pharmacy
Shilo Murphy	People's Harm Reduction Alliance (PHRA)
Steve Stocker	Auburn Police Department
Jim Pugel	King County Sheriff's Office
Thea Oliphant-Wells	King County Needle Exchange
Laurie Sylla	King County Department of Community and Human Services
Marcee Kerr	Public Health - Seattle & King County

Policy Workgroup

Member	Agency/Entity
Brad Finegood	Department of Community and Human Services
Scott Lindsay	City of Seattle Mayor's Office
Mark Larson	King County Prosecuting Attorney's Office
Mark Cooke	American Civil Liberties Union (ACLU)
Lisa Daugaard	King County Public Defender Association
Kris Nyrop	King County Public Defender Association
Patricia Sully	King County Public Defender Association
Shilo Murphy	People's Harm Reduction Alliance
Annette Hayes	U.S. Attorney for the Western District of Washington
Steve Gustaveson	Department of Community and Human Services
Chelsea Baylen	Department of Community and Human Services

Evaluation Workgroup

Member	Agency/Entity
Caleb Banta-Green	University of Washington Alcohol and Drug Abuse Institute
Sara Glick	Public Health – Seattle & King County
Julia Hood	Public Health – Seattle & King County
Laurie Sylla	Department of Community and Human Services

Attachment D

Community Conversation (May 31, 2016): Attendee Comments

Focus One: Primary Prevention

What is Working Well?

Adverse Childhood Experiences (ACES)

- The ACES work has also been extremely successful in identifying the key trauma areas and identifying that certain people just based on their childhood trauma may be more inclined.

Awareness, Social Norms, Education, and Training

- Education to the community has been good.
- 'Providing Good Choices" Parent program educates parents and gives them tools to get children to open up about issues. It works with different languages and faiths. Talking about issues allows more opportunities to address issues
- Altering points of view – debunking the illusion of 'everybody else is using'. Show that drug use is not the social norm among the kids' peers. This can lead to a positive 'reverse peer pressure'.
- The community was working to relay 'positive community norms' through groups such as Youth Eastside Services (YES).
- These forums are working well they generate discussions, provide education, they are informative and bring community partners outside of the traditional; law enforcement, mental health, healthcare providers together. Adding all these other entities makes it much more educational.
- Awareness is growing. My daughter died four years ago and we were fighting hard to keep her alive and it was difficult. People are starting to understand it is a disease, the stigma is going away, there is a shift towards awareness and what addiction really is and what it does to someone. We still have a long way to go, but it's getting better, for instance, there is a meeting tonight in Kirkland to discuss these issues.
- It is so amazing that it is being spoken about, it is out there and people are now talking about it openly.
- There is a lot more understanding and it has been great that people now understand that it is not just poor people that are impacted and there is also the issue that folks understand it is happening with younger and younger youth.
- In the past they did campaigns that I felt were effective; the faces of Meth, DARE and while I know many feel that was a bust, I still remember it and it was helpful to some.

- Awareness is big right now because unfortunately no community is untouched and it is becoming really frightening. Look at across the country it is a nationwide epidemic of Heroin and opiate use.
- It is good to see that people understand that this is not a socioeconomic issue, it is not a problem in only one area, it is a problem that is impacting everyone, and it is touching all spectrum of life.
- The discussion is becoming honest. There is no longer terror or the bogey man associated with the problem. People are having honest, clear discussions.
- The discussion has become honest and moved past the bumper sticker. It has become educational and part of a broader conversation about how to address the issue and how officials can tie down the problem to really help those that need the help.
- The media has done a good job, have learned a lot about from the news about the opiate crisis. It is a little late, but at least the story is being told now. I have been informative and it is really helpful to have them at the table. (Asked for examples)
- I am from Kentucky and would not associate the issue with them, but there are so many pill factories there and now look at the big Opiate/Heroin crisis going on there. The Frontline story was also good.
- Students/teachers/administrators know which substances are being used in the community and what local resources are available to assist with intervention efforts
- Training for administrators/teachers on warning signs of substance use so those interacting with school-age children can identify those at risk and can target prevention and intervention efforts accordingly
- Lots of people are here and it's because people are dying and it is starting to get people's attention.
- Many communities are ''owning'' the issue, realizing that this is a problem and it needs to be addressed. Though there are still some areas that are in denial.

Collaboration

- Various agencies are sharing information and training opportunities.

Continuum of Care – Comprehensive Strategies

- As I approached the table I thought the prevention meant to stop people from starting to use, but now I see it can mean several things, the prescribing habits, the reviving of people, getting people into effective treatment and other things to be done to prevent continued use.

Narcan/Naloxone

- The shift to harm reduction is great. Lots of attention on providing information to those in need and the efforts to address the overdose situation has been great. There are lots of efforts to get information out to first responders and provide the NARCAN kits. The "MARAH Project" has funded the Seattle Police Department with NARCAN kits and in 6

weeks has saved 6 lives – this was so encouraging and shows the importance of these kits and getting them out to first responders.
- A study at Evergreen Treatment Services regarding the distribution of NARCAN to users and how and is it being used has been helpful. They are keeping stats on how often the NARCAN is being used and it has shown that it is not uncommon to have NARCAN used by someone more than once.

PDMP

- Prescription drug monitoring program and the take-back program were very positive and working well.
- Prescription monitoring programs are an effective tool for any prescriber who needs or wants to use it. But it is not being used by many. If they use it they are can look at what folks are getting and prescribe smartly

Peers

- Using peers to engage other students in prevention education and identification of peer role models to assist with prevention and engagement efforts

Prevention Interventionists in Schools and Counselor Support

- The high schools have behavioral counselors who are termed ‘coaches’ but there is a need for more of them
- Engaging school-aged children through the school system (Boston model)
- Providing targeted prevention intervention for school-aged children who have family members with opiate use disorders or other substance use disorders
- Using prevention interventionists in schools (need more of these professionals)

Resources and Support

- Advocates being available for families have been really helpful. It has helped families to not be alone through the treatment process, and knowing where to go when they need help.
- Drug-free community grant
- Annual Prevention Conference in Kent (Kent Drug Free Coalition) and Peer to Peer Annual Education Conference
- CVS Pharmacy grant involving prescription take-back

Syringe Exchange

- Needle and syringe exchange programs have been helpful

Take-Back Boxes

- Talked about prescription take back boxes in all of their schools and that there is a great deal of buy in from the mayors, police chiefs, libraries and chambers of commerce in her

area. She states that there is a lot of sharing of information among these entities regarding 'the word on the street'.
- Prescription drop boxes in Police Departments are well received, but many may be intimidated by the location.

Youth Engagement

- Engaging students in the process of determining prevention content

What Needs to be Improved?

Adverse Childhood Experiences (ACES)

- ACES is a good start

Accessibility and Equity of Information

- Information needs to be in a broad spectrum of languages and written so that it is respectful of culture
- When family are immigrants the parents often do not speak English well/at all and are not culturally aware and so kids can take advantage of this.
- Need more culturally appropriate services (including services for those with English as a second language)

Addressing Mental Health and Co-Occurring Disorders

- Mental health treatment is a big issue. My daughter had several diagnoses and it made her anxious and unstable. She chose to self-medicate and even with all our efforts to help her, we could not get to her before she died.
- All agreed that Mental Health services in the county and state are lacking.

Alternative Pain and Traumatic Injury Treatments

- Alternative medication or treatments for pain from traumatic injuries

Attitudes

- 'If it makes you feel good, do it' attitude
- Past culture of opioid use – early medicines that were cure-alls, some Asian cultures where opium use was very acceptable at times in the past.

Beds and Housing

- Treatment facilities and after treatment housing needs to improve with more beds available.

Data to inform prevention efforts and policy

- Need access to community/neighborhood-centric data to impact and inform local prevention efforts and policy; also need education on where/how to access county-level and city-level data (some communities are currently utilizing national or state level data to inform local prevention efforts)
- Need access to data on young adults/transition aged-youth (18-25 year olds)

Diversion Programs

- Diversion opportunities need to be improved. There needs to be more opportunities for folks who are in a clean and sober situation to keep active whether it is a community project or just creative tasks for them to have an outlet.
- Expand the Law Enforcement Assisted Diversion (LEAD) program

Education – Information Dissemination

- Smoking heroin does not seem that bad to many , so informing early and informing accurately is important
- When we get funding we need to ensure education is a part of the requirement
- How are people teaching about it needs to be more than bumper sticker. Needs to be more than scare tactic and abstinence

Financial resources to target problem

- It feels like we are restricted in regards to how much we can do: Federal funding can be utilized, it feels like resources are there, the State is working with the Government for funding. The more we can get the better, because in the long run it will not only save lives, but money.
- Need more federal funding without strings: The problem with this is the restrictions around the funding that often hampers the ability of who you can help
- You have to wonder if the strings are meant to clutter the path for exclusionary reasons. One guess is that it is a manifestation of political fear - If one signs over funds to help people their constituents feel are not worthy, there may be fear the people who voted for you would vote you out.

Good SAM Law

- Broadcast ‘Good Samaritan Laws’ regarding calling 9-1-1 for overdoses – Police will not arrest person calling or victim, they just want people to get medical attention.

Legalization

- I think the best thing to do is to legalize everything – I know this is a controversial perspective, but what happens that right now we can’t safely engage the issue when we drive them deeper into hiding. We would get more momentum to the legalize trade than to treatment

Mental Health Screening

- Mental health screening is important – there needs to be a variety of education in this area.

- Maybe some kind of mental health screenings in schools, in adolescents or primary schools that would help identify the issues. A screening and brief intervention in the mental health setting would be great. There really need to be a lot more screening and intervention; more of a broad based screening, need more resources, it needs to be widespread, routine and it really needs to become common practice.

Narcan/Naloxone

- Regarding Narcan in Seattle: There are some politics around this especially with Fire – there is pushback. Medic-one carries the kits but Fire doesn't and wont – something to do with first on the scene. It took a year to get Seattle Police Department (SPD) to get on board. Approached the Mayor's Office but they just kind of gave the run around and no real assistance, made lots of efforts, but could not get them on board, we just heard, "okay, yeah, we'll look at it." It did not happen until we approached Chief O'Toole and it happened. She was extremely helpful and open to the idea. The project's goal is to save lives and it was so nice and interesting to see that it was successful and the results were seen so quickly.
- We want everyone in Seattle Police Department to carry the Narcan kit, we want to get parents to understand that buying a kit could save their child's life – recommend buy a kit, give it to them and teach them how to use it to save their child's life.

National support and promotion

- Educational information is good at the local level, but really needs to also be at the national level – forums like this one need to occur at a higher level. Public Service Announcements similar to the one Obama and Macklemore did was great.
- Look at the bill Obama did: one bill for the Opiate addiction and medication-assisted therapy.

Parent Education

- Need to train parents that prevention education will not encourage use

Patient Education

- My doctor and/or pharmacist did not tell me I could overdose

Prescription Drug Monitoring Program (PDMP)

- Prescription monitoring programs are an effective tool for any prescriber who needs or wants to use it. But it is not being used by many. If they use it they are can look at what folks are getting and prescribe smartly

Prescriber Education and Prescribing Practice

- Education and cooperation by prescribing doctors needs to be better.
- Supply is an issue, but informing youth early on so young people have time to make decisions about what they are going to do.

- You can't buy Opiate prescription now, it is all in the medicine cabinet – doctors are prescribing ridiculous amounts for benign things like. I had 30 for a hurt wrist and I have 30 for a pulled wisdom tooth and that is ridiculous
- Need more info on practitioners who over-prescribe

Reduce Access/Availability of Drugs

- Availability for people to get drugs

Resource Awareness for Law Enforcement/first responders

- Better educate law enforcement (first responders) about what prevention opportunities and resources are available so they can pass info on to folks they come across in the field.

Resource Awareness - Narcan/Naloxone and Take-Back Boxes/Events

- Provide better information on where to get Narcan
- Need more information about prescription take-back and prescription take-back events and permanent drop-boxes at appropriate/supervised locations

Safety

- There is no way to evaluate street drugs for safety

School Policy

- Kicking kids out of school for drug use enhances the problem – keep them in class and get them counseling.
- Random drug testing? – It is not allowed in schools; however, parents can have kids tested.

School and Youth Prevention Programming/Education, Intervention and Mentoring

- Improve education in the schools at all levels – drug abuse programs
- Informing young people about Methadone is key – we need to inform them. The thing is we focused on Crack, we focused on Meth and other types of drugs and maybe it made it look like Heroin may not be so bad, if they are focusing on the others. We need to make sure to inform youth better about heroin and opiates. People start using them and then it is on from there. They get that thing into their brain and then it is over – addiction.
- Need more prevention-interventionists in schools
- Need more healthy support networks and mentoring programs in our schools
- We need to provide alternatives to using drugs – keep the kids engaged.
- Empower children to make educated decision.

Social Norms and Media Messaging

- Social settings where drug use is the 'norm' and where drug use is being 'normalized' and where social media messaging promotes that drugs are 'fun'
- Movies and TV showing drugs as fun

- Needs to be more education to youth through TV, social media, other sources

Training – administrators, teachers, and parents

- Need to provide more training to school administrators, teachers, and parents on early identification of at-risk youth (what are the substances being used in the community? what are red flags to be looking for? what are local resources for intervention?)

What works? – Use research-based approach – Address issues to reduce risk

- In regards to homeless youth and the use – there are many that don't use, so what made the difference, was it early intervention?
- What works with kids not using?
    - Not being homeless – housing is a huge issue
    - Making kids excited about life
    - Employment programs
    - The availability of other options – healthy activities
    - Young people need really good non-scare tactic information
    - There needs to be engagement and the availability of all services – especially mental health

Focus Two: Treatment Expansion and Enhancement

What is Working Well?

Approach

- Shift in acceptance of Harm Reduction
    - Assigned police staff for community resource

Awareness, Attitudes, and Reduced Stigma

- More awareness and push to acknowledge the issue. The amount of discussion of problem
- A growing understanding that recovery is a process
- Society is coming to understand that opiate addiction is a disease, not a lifestyle
- Society is also seeing this current issue as a Public Health issue rather than a criminal justice issue.
- Shifting attitudes about medication for treatment
- Humanizing the problem
    - Schools are involved in the discussion
- Stigma is being addressed, compassion is happening
- Awareness and Education efforts are increasing.

Behavioral Health Integration and Language

- Merging of mental health and substance use treatment allows for better tracking of needs

- The County's Department of Community and Human Services, Behavioral Health and Recovery Division (BHRD) name change shows emphasis on recovery and holistic wellness not "illness."

Best Practices and Science

- Identifying 'best practices'
- Emphasis on science instead of morals

Continuum of Care

- The focus on medication-assisted treatment is good, seeing it explored is a popular topic because abstinence does not work. It is good to see it being recognized more as a disease model. Telling people to say "no" and "why aren't you strong enough to say no," is the wrong message, because all it does is cause people to beat themselves up.

Media

- Media is presenting factual information as well as the grief in the community
  - Normalizing of the topic, bringing new voices to be heard

Narcan/Naloxone Access and Promotion

- The availability of Naloxone for users and family members
- Putting Narcan into treatment plans- for example, asking "who do you trust" to help you in an emergency and getting a plan in place just in case.

No wrong door approach

- Where it exists, the "no wrong door" approach is working.

Open Access

- Same day assessments and next day assessments are very helpful
- Next day appointments-treatment when you need it.

Opportunities and Solutions

- Feels like opportunities and new solutions are happening

Peer Support and Recovery Coaches

- Peer support, recovery support services exist, recovery houses
- Peer Bridger programs are very successful
- Recovery coaches are proving to be a promising practice
- Peer coaches seeing the community respond to peer coaches that are more client centered than sponsors "who tell you what to do instead of asking you what you'd like to work on"

Programs

- Innovation in the Law Enforcement Assisted Diversion (LEAD) program
    - Social services and law enforcement working together

Provider Communications

- Communication between providers

Treatment, Access, and Availability

- Increase in services available
- More treatment availability in pipeline
    - Greater access in areas that need it – that is, South King County
- More treatment options are serving more people
    - Suboxone providers/opiate treatment programs
- Methadone treatment is effective.
- New treatment options and drugs are coming on line.
- More treatment centers are opening in south King County
- Methadone and Suboxone treatment
- There is a demand for treatment (which is a good thing.)
- Small pilots for treatment on demand working well. Need to bring them to scale

What Needs to be Improved?

Attitudes, Stigma, Need for Education

- The negative stigma that impacts family members of users (lack of education)
- The assumption that users come from poor, broken families (education)

Community Concerns – Service Locations

- Community concerns over siting future clinics

Criminal Justice

- What is criminal justice doing?

Funding Needs

- Lack of funding

Housing

- Housing is a big one – various options are needed, it cannot be the same for everyone there needs to be different options. There are not enough treatment options that include housing.

Lack of Comprehensive Wraparound Systems

- Lack of a comprehensive wrap around system for users and recovering addicts. For example ongoing counseling, job opportunities, family support, and developing skills to transition to a drug-free lifestyle.
- 24 hour "wraparound services" in a shelter setting with a one-stop type of approach – for example, DSHS workers, housing workers, etc. – like the San Francisco "The Navigation Center" shelter and "radical hospitality" – and allows clients to bring with them the three Ps – pets partners and possessions (Seattle does this some places) since King County is more spread out that there may need to be more navigators (also Councilmember Bagshaw)

Libraries and Social Worker Support

- In Colorado, Denver employs social workers in the library or libraries to provide support, case management and this County should look at that option.
- Train librarians on options for people in need as well.

Low-Barrier Services and Shelter

- Develop a center like the Navigation Center in San Francisco that offers low barrier services and shelter. This center allows all genders, dogs, and a full array of services for people.

Meeting the needs of communities of color and priority populations

- What about communities of color in the data and media and workforce?
  - Family supports
  - Navigating the system for families and users in a culturally relevant way
  - A need for more trauma-focused care
  - Increased education across all demographics/211 system
  - Increased information about medications and side effects, esp. with various populations
  - Getting treatment to be outside of the agency - information
  - More/better relapse prevention strategies such as education and when relapse happens
  - More support services that are free; peers, youth
  - Inclusive models of care - both mental health and substance use and 1degree care
  - Have treatment options in increased varied environments, greater access
  - Increased sober housing; integration of treatment w/ housing programs; more housing first programs
  - Efficient allocation of funds - more to treatment, less to admin
  - Lower income, working class need more funding
  - Single parents, pregnant women, LGBTQ, veterans, non-native English and non-English speaking individuals - targeted programs for groups with high barriers

Negative Impacts on Environment (places)

- The negative impacts on public spaces such as a library – presence of users, needles, etc.
- The feelings from librarians that they are being forced to become social workers to respond to users and patrons of the library system.

Open Access

- Increasing the numbers of substance use next day appointments that the Crisis Clinic has to offer. Immediate access to care was something that came up as key to individual's recovery. Once someone is open to detox, having quick access to a bed would not only provide treatment, but encouragement the person is making a healthy choice the community supports with resources.

Safe Injection and Consumption Sites – Equity Measures

- Need not only safe injection sites but safe consumption sites since this is equitable given that there are more white people injecting and more African-American people consuming (smoking) (From Sally Bagshaw, City of Seattle Council member)

Shortage of Treatment Professionals and Prescribing MDs

- Shortage of Chemical Dependency Professionals (CDP)
- Nursing shortage
- Lack of doctors prescribing---how do we incentivize them? Tuition forgiveness? Other options?

Transportation Access

- Lack of transportation options

Treatment Access, Approach, and Options

- Lack of available methadone treatment centers
- Poor accessibility of current methadone treatment centers
- Lack of services outside of Seattle
- No plan for early engagement for users who have just started
- Develop standard treatment guidelines for treatment providers around overdose prevention.
- More and expanded treatment on demand
- Less focus on abstinence based treatment more hard reduction focus

Focus Three: User Health and Overdose Prevention

What is Working Well?

Awareness, Attitudes, and Reducing Stigma

- Awareness (PBS Frontline, Vancouver's Insite visit and other events)
- Increasing public awareness
- Decreasing stigma
- Better attitudes of treatment whole person
- Becoming less judgment and more supportive

Behavioral Health Integration

- Behavioral Health Integration
- Behavioral Health Organizations (BHO)
    - Integration of primary care with Evergreen Treatment Services/Harborview
    - Physicians on staff @ methadone clinic

Community

- Community discussions
- Voices from community members most affected such as Voices of Community Activists and Leaders (VOCAL)

Decriminalization

- Movement toward decriminalization of drugs

Law Enforcement and First Responders

- Police/first responders

Naloxone Access and Promotion

- Getting Naloxone into schools
- Narcan in housing programs
- Naloxone
    - Police are carrying, using and reversing overdoses
    - Change in law in Washington is resulting in increased access to Naloxone
- Naloxone access

Needle Exchange

- Needle exchange
- Needle exchange

Parent Involvement in Programs

- Parental involvement in treatment programs (NAVOS)

Partnerships and Collaboration

- Partnerships, like between the King County Behavioral Health Organization, Kelley-Ross Pharmacy, and agencies like Community Psychiatric Clinic (CPC).

Peer Models

- Peer-based models such as People HR Alliance
- Peer-based support is effective

Programs

- The REACH Program of Evergreen Treatment Services
  - Outreach services to homeless
- Law Enforcement Assisted Diversion (LEAD) criminal justice diversion program

Race, Culture and Equity

- Better recognition of need to consider issue of race and culture

Resources

- Stopoverdose.org
- Connection to info about services

Treatment Expansion, Access, and Approach

- Methadone clinics expanding due to County and increased cap (Renton, Kent, eastside)
- Buprenorphine prescriptions by some docs
- Suboxone less difficult to kick than methadone
- Medical assisted treatment overall
- Harm reduction
- Medic One
- Increased treatment capacity (Renton Youth Treatment Services, Evergreen Treatment Services in Grays Harbor, etc.)
- Mobile Clinics (with limited primary care resources)
- Flexcare (Buprenorphine) medication-assisted treatment
- Access to methadone for pregnant women
- Access to methadone and Suboxone

User Education and Harm Reduction

- User education re-harm reduction

Wrap Around Services/Teams

- Wraparound services/teams
`

What Needs to be Improved?

Access to Services, Equity and Social Justice, and Increasing Providers/ Capacity

- Services needed in all cities
- Not enough access – geography, level of severity, treatment slots
- Limit on Buprenorphine prescriptions
- Mobile SCF to reach homeless people with others
- Expanded access to Suboxone
- More Suboxone prescribers

Best Practice

- Info about best practices

Care Model

- Providing comprehensive care

Education for Community/Public and Outreach

- More public education needed
- Community education to reduce “not in my back yard” responses and create “yes in my back yard” responses
- Utilize churches for outreach/education

Education for Youth

- Prevention education for kids

Education for MD Providers

- Education of next generation of doctors, those in med school
- Better education of medical professionals re: Suboxone

Equity and Social Justice, Sentencing Guidelines, medication-assisted treatment in Drug Court and Public Health Focus

- Only focused on heroin because it affects white middle class
- Revisit drug sentencing guidelines
- Acceptance of medication-assisted treatment for people in drug court – education of judges
- Less criminalization, more public health focus

Expand Peer Program Resources

- Expand information/tools/recovery resources for peers

Funding

- Maintain funding support for programs
- Flexible funds for people in recovery

Homeless Population Support and Access

- Valley Cities Counseling is teamed up with the King County Library System to assist with the homeless populations that are users within the downtown Renton branch with limited success.

Integration of Recovery Discussion

- Integrate people in recovery and discussion of drugs into other committees (housing, schools, etc.)

Mental Health and Co-Occurring Support

- Mental health support for those struggling with addiction issues
- More integration of primary care with behavioral health.

Narcan/Naloxone Access and Education

- More Narcan kits into hands of active users
  - Costs have risen, reducing number given to agencies
- After naloxone, then what?
  - Use media to help educate on what to do after someone is recued (next steps)

Narcan/Naloxone and medication-assisted treatment in Jail

- Jails should give naloxone and allow people to stay on medication-assisted treatment

Open Access

- Treatment on demand
- Need more treatment on demand
  - Utilize the Downtown Emergency Service Center (DESC) or other resources

Opportunities and Meeting Basic Needs

- Creating more opportunities for people in recovery (jobs, housing, education, etc.)
- Need more stable housing/affordable housing

Patient Education and Support

- Educate pharmacy on how to address addiction. How to talk to patients or doctors.

Reduce Access to Prescription Opioids

- Too easy to get prescription opiates

Reducing Stigma

- Stigma – must pay attention to use of language

Supervised Consumption Sites

- Supervised consumption sites
- Insite approach
- Safe consumption for all drugs
- Supervised consumption sites connect people to treatment
- Call it “supportive consumption facility”

Systems and Leadership

- Need to challenge prison and law enforcement systems
- More civic and law enforcement leadership
- Improve power sharing among decision makers

Attachment E
SUMMARY OF RECOMMENDATION VOTING TALLY

RECOMMENDATION	VOTING TALLY
PRIMARY PREVENTION REC#1	Y=24, N=0, A=2, S=4
PRIMARY PREVENTION REC#2	Y=25, N=0, A=1, S=4
PRIMARY PREVENTION REC#3	Y=25, N=0, A=1, S=4
TREATMENT EXPANSION & ENHANCEMENT REC#1	Y=25, N=0, A=1, S=4
TREATMENT EXPANSION & ENHANCEMENT REC#2	Y=26, N=0, A=1, S=3
TREATMENT EXPANSION & ENHANCEMENT REC#3	Y=26, N=0, A=1, S=3
HEALTH SERVICES & OVERDOSE PREVENTION REC#1	Y=23, N=1, A=1, S=5
HEALTH SERVICES & OVERDOSE PREVENTION REC#2	Y=23, N=3, A=1, S=3

Note: The Health Services and Overdose Prevention Workgroup Recommendation 1 was approved via an electronic voting process.

Y=YES N=NO A=ABSTAIN S=SILENT

Attachment F
IMPLEMENTATION AND PLANNING DETAILS
Primary Prevention Workgroup Recommendation 1

- Creation and Dissemination of Educational Flyer and Counseling Guide
  Current implementation and planning: A new approach to education, potentially facilitated by an educational flier, could be implemented when considering opiates for a pain condition. The flyer is intended to help facilitate conversation about the risks and benefits of opiate drugs, including the risk for overdose, addiction potential and other risks associated with the medication and to provide information on non-opiate alternatives for treating pain. Dissemination of the educational approach/flier will be supported by King County agency staff, UW partners, local stakeholders and professional associations.

- Education Campaign
  Current implementation and planning: An education campaign will be developed in partnership with local stakeholders, King County DCHS Prevention Staff, and Washington state workgroups to build capacity, partnership, and overall effectiveness in launching a comprehensive and unified educational campaign to reach a broad audience including the general public, opiate users, social networks, and professionals.

Attachment G
IMPLEMENTATION AND PLANNING DETAILS
Primary Prevention Workgroup Recommendation 2

- Encourage pharmacies to counsel all individuals on opiate use, storage and disposal
  Current implementation and planning: King County pharmacies will be encouraged by King County Agency and involved community stakeholders to counsel all individuals at the time of first prescription regarding safe storage, disposal of opiates and other controlled substances to prevent unintended access to the medications by others, and how to prevent and recognize overdose.

- Increase pharmacy participation in promoting safe storage and medicine disposal
  Current implementation and planning: King County pharmacies will be encouraged by local stakeholders and King County agency staff to promote safe storage and medicine disposal with each opiate prescription to expand community opiate prevention and awareness across all areas in the county.

- Expand access to and coordination with prescription-take-back programs
  Current implementation and planning: Task Force members and King County prevention staff are currently partnering with King County Secure Medication Return to promote the expansion of their take-back locations and mail back program. Partnership includes unifying messaging and incorporating consistent guidance on disposal methods for medication types.

- Engage local pharmacies to distribute mail-back envelopes
  Current implementation and planning: The Cordant pharmacy launched a program in July 2016 to provide free take-back envelopes to the public through partner agencies to collect and dispose of unwanted medications with the aim of contributing to a reduction in the opiate crisis. King County is ordering 5,000 Cordant mail back envelopes to begin piloting distribution of a postage paid take-back envelope to be paired with each opiate prescription dispensed in addition to related opiate prevention counsel by pharmacist.

- Use social media to promote safe storage and disposal of medications
  Current implementation and planning: Task Force members and King County staff will outreach and partner with agencies, prevention coalitions, and pharmacies to promote safe storage and disposal.

Attachment H

SAN FRANCISCO INTEGRATED BUPRENORPHINE INTERVENTION SERVICES (IBIS) PROCESS PROTOCOL

Brief Program Description

The IBIS Program represents a collaboration between the San Francisco Department of Public Health, Community Behavioral Health Services (CBHS) and the UCSF Department of Psychiatry at San Francisco General Hospital. The program identifies, evaluates and provides buprenorphine treatment to opiate dependent adults residing in San Francisco. Indigent, out-of-treatment, injection heroin users represent the primary patient population. IBIS is a maintenance (vs. detoxification) treatment program. Most IBIS patients begin buprenorphine treatment at the City's **Office-based Buprenorphine Induction Clinic (OBIC)**, and stabilize for a period time prior to transfer to a participating community-based IBIS provider. Community IBIS sites include a number of Primary Care and Mental Health clinics/programs. Indigent IBIS patients can receive Suboxone free-of-charge through the CBHS Pharmacy.

Program Eligibility

- Opiate Dependent San Francisco residents who are eligible for care in the SFDPH Community Oriented Primary Care Clinics (COPC). Must have Healthy San Francisco, S.F. Path, Healthy Families, Healthy Workers, San Francisco Health Plan, Medi-Cal or other coverage accepted by the COPC.
- Absence of benzodiazepine abuse or misuse
- Absence of current alcohol dependence or binge drinking
- 18 years or over or emancipated minor able to consent for medical and substance abuse treatment
- No medical or psychiatric contraindications for buprenorphine maintenance treatment (for example, unstable medical condition, active suicidal ideation, marked psychosis etc.) Any hepatic dysfunction must be in the mild-to-moderate range, with LFTs no greater then 5xs normal levels.

- Patients with acute or chronic pain syndrome requiring regular opioid analgesics should be carefully screened, as buprenorphine may provide less analgesia than a full opiate agonist, and will block (or partially block) other opiate agonists.
- Patients currently receiving more than 30mgs of methadone daily will likely be required to taper down to a dose ≤ 30mgs prior to their first dose of buprenorphine.
- Women who are pregnant (or trying to become pregnant) should be evaluated on a case-by-case basis. Though methadone remains the standard of care for pregnant opioid dependent women, recent data support the safety and efficacy of buprenorphine in pregnancy.

Patient Identification, Referral, and Program Entry

To be eligible for treatment through IBIS, a patient must meet the above eligibility criteria and be able and willing to comply with program expectations, including compliance with counseling, medical, and pharmacy visits. Patients may be identified at, and referred to IBIS from, multiple sites/venues/providers across the City including, but not limited to, primary and mental health, social and outreach services (for example, Homeless Outreach Team, Project Homeless Connect and needle-exchange sites), and the Centralized Opiate Program Evaluation (COPE) Service. In certain circumstances patients may self-refer to OBIC/IBIS.

Potential IBIS patients must be discussed with medical staff at OBIC (552-6242) who will make a preliminary determination of appropriateness for buprenorphine treatment. Patients will typically be referred to OBIC for evaluation and medication induction. On occasion, induction can occur at the referring site.

OBIC Clinic Procedures

The Orientation Appointment

At the orientation appointment, patients meet with OBIC staff and review the OBIC/IBIS program, as well as potential benefits and side-effects/risks of buprenorphine. Typically at this visit, consent forms are reviewed and signed. If lab-work is indicated (for example, LFTs), the patient will be given a lab-slip to have their blood drawn at SFGH. Patients must have or obtain a CHN (Community Health Network) number in order to participate in IBIS. Induction procedures and expectations are reviewed, and after preliminary work is completed an induction appointment is scheduled. On rare occasions, the induction process may begin at the orientation appointment. Patients may be given adjunctive medications such as clonidine and trazadone at this appointment to help them prepare for the induction.

The Induction Appointment

At the induction appointment, preliminary labwork is reviewed, and a diagnosis of opiate dependence is confirmed. A point-of-service urine toxicology screen will be obtained. The patient receives a thorough medical, mental health, substance use and psychosocial assessment, and a physical examination is performed. If a recent physical exam, history, and/or

labwork have been conducted by the referring physician, a copy should be faxed to OBIC for review. **Patients must be in opiate withdrawal in order to be induced**. The only exception is a patient who has not used opiates for several days prior to the appointment. Patients who have recently ingested an opiate and do not appear to be in withdrawal may be asked to return at a later time. If deemed ready for induction, an initial dose of Suboxone will be administered. The patient is observed for 1-2 hours, and may receive additional Suboxone doses as determined by the OBIC physician. Adjunctive medication such as clonidine and trazadone may be dispensed to the patient to help them through the first days of the induction. Follow-up appointments to stabilize the dose are scheduled by OBIC staff.

Induction and Stabilization at OBIC

OBIC patients are generally seen daily during the first week of treatment (the induction period). The frequency of appointments typically decreases over the ensuing weeks. Most patients will reach a stable dose in less than 2 weeks, and typically progress to a weekly then bi-weekly dispensing schedule as determined by the IBIS physician. Buprenorphine is dispensed through the CBHS Pharmacy located 1 floor below OBIC at 1380 Howard Street.

Substance abuse counseling is required at OBIC during the induction and stabilization process. In addition, all OBIC/IBIS patients are encouraged to attend weekly group sessions with other patients in office-based opiate treatment. Urine toxicology screens are obtained at regular intervals while the patient is at OBIC. Communication with the referring site will occur while the patient is at OBIC.

For those patients who are not already engaged in Primary Care or Mental Health treatment at a participating community IBIS site, OBIC staff will review previous and current medical, mental health, substance use and psychosocial needs and work to match the patient to a community IBIS provider. Once an accepting community IBIS site is identified, OBIC staff will facilitate a transfer for ongoing care. Typically, patients spend 4 to 8 weeks at OBIC for stabilization and are then transferred to a community site; however, care at OBIC is based on individual needs and the treatment timeline will vary. In rare instances, if approved by the OBIC Director and Medical Director, a patient may remain at OBIC for ongoing treatment.

Transfer to Community IBIS

When the patient is clinically stable and has an appointment scheduled at an IBIS community site, OBIC will fax a treatment summary and any other requested information (for example, consents, H & P, etc.) to the referring/accepting community physician. The patient will receive buprenorphine at the CBHS Pharmacy. The OBIC physician will write the “transfer” prescription for Suboxone, and fax this to the pharmacy. This prescription will carry the patient through to their next community IBIS physician appointment. Patients with MediCal may have their Suboxone dispensed from a local community pharmacy other than the CBHS Pharmacy. All subsequent prescriptions will similarly be written by the IBIS community physician and faxed to the community pharmacy. The CBHS Pharmacy will accept only faxed and phoned prescriptions. NO WRITTEN PRESCIPTIONS SHOULD BE GIVEN TO PATIENTS.

Maintenance Treatment Considerations

Clinic Visits

Some form of counseling is recommended for all IBIS patients. Physicians, nurses, social workers, behaviorists, and/or counselors can provide counseling. The prescribing physician may require the patient to attend support groups. Patients should meet with their prescribing physician regularly, with physician-determined visit frequency based on patient functionality, response to treatment, and adherence to the treatment plan.

Toxicology Screening

Toxicology screening is recommended for IBIS patients, particularly early in treatment, during periods of instability, and when indicated by patient history or appearance on examination.

Attachment I
BUPRENORPHINE SYSTEM OF CARE: IMPLEMENTATION AND PLANNING DETAILS

Treatment Workgroup Recommendation 1

Level 1 Facilities

- Downtown Public Health Needle Exchange Induction Site
  Current implementation and planning: A design team has been established by Public Health-Seattle & King County to implement a centrally located, low-barrier buprenorphine induction site at the Downtown Public Health Needle Exchange. This facility has an on-site pharmacy and will provide individuals in need of buprenorphine treatment with treatment on demand utilizing a "Buprenorphine First" model of care and intensive oversight dosing. Similar to the San Francisco model, a Nurse Care Manager model will be utilized to support treatment on demand and address barriers to buprenorphine prescribing; additionally other supportive services will be available on site (see Attachment E for Description of Collaborative Care/Nurse Care Manager Model). A Collaborative Care/NCM model has also been successfully implemented in Massachusetts to expand treatment access.[43] Implementation of induction services is tentatively scheduled for end of September 2016.

- Emergency Department Induction Sites
  Current implementation and planning: A subset of the Task Force is working on determining feasibility of buprenorphine induction in Emergency Departments (ED). Harborview Medical Center, represented on the Task Force, has drafted a proposal for induction of buprenorphine in their ED in conjunction with a brief intervention and referral for ongoing care, similar to the intervention ED staff use to treat other chronic and relapsing health conditions. Harborview Medical Center is considering leveraging an existing Substance Abuse Mental Health Service Administration (SAMHSA) grant to provide induction services, and will continue to identify and address barriers to implementation.

- Recovery Center Valley Cities Detox and Residential facility
  Current implementation and planning: The Recovery Center will re-open by the second quarter of 2017. This facility (previously Recovery Center King County, RCKC), will provide approximately 30 to 35 detox beds and the same number of residential substance use disorder treatment beds. Valley Cities, represented on the Task Force, has drafted a proposal for inclusion of buprenorphine medication (induction and maintenance services) as part of the treatment resources offered to individuals seeking

[43] LaBelle, C. T., Han, S. C., Bergeron, A., & Samet, J. H. (2015). Office-based opioid treatment with buprenorphine (OBOT-B): Statewide implementation of the Massachusetts collaborative care model in community health centers. *Journal of Substance Abuse Treatment, 60, 6-13.*

treatment at the Recovery Center. Valley Cities will work with the King County Behavioral Health Organization to address barriers to implementation.

- Mobile Medical Van
  Current implementation and planning: As of July 2016, Public Health - Seattle & King County operate two Mobile Medical Vans (MMVs). These vans provide an array of health care services including basic medical care, behavioral health assessments and initial interventions, social service assistance, and referral to ongoing care. The MMV staff have the ability to prescribe buprenorphine, monitor the induction process, and provide brief intervention and referral for ongoing care. As such, the MMV offers a unique opportunity to reach individuals experiencing homelessness. Effective September 2016, Public Health-Seattle & King County, represented on the Task Force, will implement a pilot program to provide buprenorphine induction and maintenance through the South King County MMV to a small number of individuals that present with opioid use disorder. The pilot program will be evaluated to determine ongoing implementation and the possibility of program expansion.

- Jail
  Current implementation and planning: A design team has been established by Public Health-Seattle & King County, Jail Health Services to determine feasibility of providing buprenorphine induction and maintenance services to individuals incarcerated in the King County jail. The first phase of implementation will focus on developing a plan to provide buprenorphine maintenance services to individuals that present to jail stable on buprenorphine. The second phase of implementation will focus on developing a plan to provide buprenorphine induction services to incarcerated individuals in need of opiate treatment. To inform implementation efforts, the design team is currently examining the number of individuals booked into the King County jail who are stable on buprenorphine treatment for opioid use disorder.

Level 2 Facilities

- Community Health Clinics (CHC)
  Current implementation and planning: Primary care settings can provide a non-stigmatizing, low-barrier environment for the provision of medication-assisted treatment. Providing buprenorphine treatment of opioid use disorder through a primary care setting would also expand treatment availability to individuals who historically have not had equal access to buprenorphine services.[44] Neighborcare Health, represented on the Task Force, has drafted a proposal for implementation of buprenorphine induction and maintenance services within the King County network of CHCs. The proposal involves the identification of senior leaders and physician champions within each CHC to provide education to staff regarding community need for medication-assisted treatment. Each

[44] Hansen, H. B., Siegel, C. E., Case, B. G., Bertollo, D. N., DiRocco, D., & Galanter, M. (2013). Variation in use of Buprenorphine and Methadone Treatment by Racial, Ethnic and Income Characteristics of Residential Social Areas in New York City. *The Journal of Behavioral Health Services & Research*, *40*(3): 367-377.

CHC would identify prescribers to become waivered to prescribe buprenorphine for treatment of opioid use disorder, and buprenorphine services would be offered utilizing a Nurse Care Manager model to support treatment on demand.

Level 3 Facilities

- Behavioral Health Clinics, including traditional Medication-Assisted Treatment (MAT) facilities
  Current implementation and planning: There are 44 behavioral health providers in the King County network; as such, behavioral health clinics represent a unique opportunity to significantly expand access to buprenorphine treatment, a standard of care for treatment of opioid use disorder. As behavioral health clinics disproportionately serve individuals with limited income, and people of color are overrepresented among those with limited income, adding buprenorphine treatment to the array of services offered by behavioral health clinics improves access and equity. Downtown Emergency Services Center (DESC), represented on the Task Force, submitted a proposal for implementation of buprenorphine services in behavioral health clinics, and identified critical resource needs. DESC also highlighted opportunities to deliver buprenorphine services outside of the clinic in community settings (for example, supportive housing, homeless shelters, etc.), in order to engage individuals who are reluctant to present to a behavioral health clinic. Since the implementation of the Task Force, MAT facilities (which have traditionally provided methadone treatment for opioid use disorder) have received state approval to dispense buprenorphine, in addition to methadone. This liberalizing legislation provides an opportunity for conventional MAT facilities (which offer methadone treatment services) to also offer buprenorphine induction and stabilization services via an intensive oversight dosing program (in accordance with a Level 1 facility) and buprenorphine maintenance services. Evergreen Treatment Services (ETS), represented on the Task Force, submitted a proposal for implementation of buprenorphine services in MAT facilities, and highlighted opportunities for increased collaboration between opiate treatment programs (providing induction and stabilization services) and the greater medical community (providing maintenance services). Medical providers in the community may be less hesitant to offer buprenorphine services for treatment of opioid use disorder if more intensive oversight services and clinical backup will be available through MAT facilities when clinically indicated.

Attachment J
DESCRIPTION OF COLLABROATIVE CARE/NURSE CARE MANAGER MODEL

Judith Tsui MD, MPH

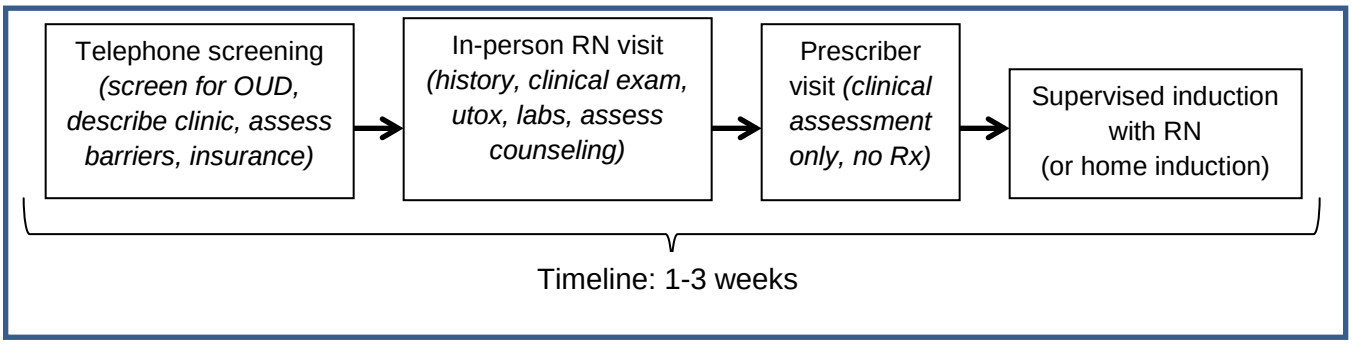
The Collaborative Care/Nurse Care Manager (NCM) model uses NCMs as the hub of the medical care team to coordinate and manage patients, supported by a program manager. The use of the NCM addresses major barriers to buprenorphine prescribing that physicians face, including insufficient time and support to accomplish the necessary steps to initiate and maintain a patient in treatment. Treatment for opioid use disorders with buprenorphine/naloxone (BUP/NX) is particularly time-intensive for the first 2-3 months. Clinical steps include: an initial screening for the appropriateness of BUP/NX; a comprehensive assessment of substance use and consequences, medical and mental health screening, and current barriers to and supports for recovery; medical review of assessment data and formal diagnosis of opioid use disorder and appropriateness for buprenorphine (that is, medication-assisted treatment, MAT); scheduling and monitoring of the induction (which typically takes place in clinic) and intensive monitoring thereafter, consisting of phone contacts and weekly visits, prescriptions, and urine drug testing for the first 1-2 months. It is unlikely that a typical prescriber could accomplish these steps within a real-world practice setting with time and scheduling constraints, yet these early steps are crucial to enhance patient engagement in care. In this model, the program manager and NCM, who are specifically trained to support office-based treatment for opioid use disorders, perform many of the initial activities, as well as the support with the induction, provision of prescriptions, and monitoring activities. This allows the prescriber time to be more efficiently concentrated on key clinical decisions (such as decisions to initiate; adjust dosage; taper; etc.). Weekly team meetings with the prescriber, NCM and program manager occur, during which team members can monitor progress and update treatment plans together.

The team roles are as follows:

- **Nurse Care Manager** is responsible for patient screening, assessment, education, care planning, medication induction, stabilization, and maintenance. Also, ongoing coordination of follow-up care, telephone monitoring when needed, relapse prevention, and support for patient self-management. Caseload capacity per nurse is 100 patients (with expected drop-out/new patients). The NCM will be available for patients during all open clinic hours, and will be a bridge to physicians, who typically have more restricted hours in clinic. The NCM may also serve as a consult/bridge to engage patients who are “non-treatment seeking” from other sites such as the emergency room or in-patient setting.
- **Prescribers** will maintain a federal waiver to prescribe OBOT medications, will conduct the medical intake to assure the patient’s diagnosis of opioid use disorder, appropriateness for MAT, determine induction setting (on-site vs at-home), write orders and prescriptions, supervise clinical services, and refer patients for counseling, psychosocial or primary care services. Prescribers at primary care clinics may provide primary care services directly to their patients, or may prescribe buprenorphine for patients who already have a primary provider in the practice.

- **Program Manager** will provide administrative support to the MAT team, conduct initial telephone screenings over the phone, help with insurance and prior authorization requirements, staffing and program issues, collaborate with referral sources, and seek referrals. He/she will also assist with assuring compliance with DEA and state licensure requirements and reporting activities.

The Collaborative Care/Nurse Care Manager Model allows patients to be more efficiently started on buprenorphine, with the process of intake as outlined below:



After enrollment, the NCM continues to see the patient weekly for the first 1-2 months, followed by every 2 week visits for 1-2 months. The prescriber sees the patient monthly or more frequently if desired at the beginning of treatment, then monthly or less frequently after the patient stabilizes. Such a schedule of visits is in compliance with the WA State Healthcare Authority's expectations for monitoring patients while on treatment with BUP/NX. The NCM can increase or decrease visit frequency depending on the stability of the patient, the mental health and substance use counseling frequency needed or desired, and the availability of the prescriber.

Attachment K
IMPLEMENTATION AND PLANNING DETAILS
Treatment Workgroup Recommendation 2

- Open Access
  Current implementation and planning: The Task Force identified that central access and referral is an integral component to achieving treatment on demand. Central access and referral will provide a coordinated model for referral management across the behavioral health treatment system and will help individuals receive care as quickly as possible and in the most suitable location. One model that is currently available that could be built upon is the Recovery Help Line (RHL). The Washington RHL offers 24-hour emotional support and referrals to local treatment services. RHL staff are supervised by state-certified mental health and chemical dependency professionals who ensure callers receive the most effective response. There is current planning at the RHL to develop what a model for local implementation would look like.

- Ongoing Assessment of Network Adequacy
  Current implementation and planning: The Task Force conducted GIS mapping of current service sites (opiate treatment programs, behavioral health treatment agencies, needle exchange facilities, public health clinics, emergency departments, and hospitals) to assess current network adequacy and geographic accessibility. This map can be accessed electronically at the following location: http://kingcounty.maps.arcgis.com/apps/webappviewer/index.html?id=d9424b892f404c39a07cda52390ce627. The Task Force also identified that the Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a list of physicians authorized to treat opioid use disorder with buprenorphine by state, city, and zip code. A review of the SAMHSA list suggests a slow steady growth of waivered physicians.

- Workforce Shortage
  Current implementation and planning: The King County Department of Community and Human Services (DCHS) surveyed behavioral health provider agencies in early fall 2015 about recruitment and retention issues. Of 29 responding agencies, 23 had vacant clinical positions, most often for four to seven weeks but some for 15 or more weeks. Most of the vacant positions were for psychiatrists, advanced registered nurse practitioners (ARNPs), or counseling staff. Over 80% of responding agencies reported that they lost employees to programs that offered better pay or benefits.[45] The King County Behavioral Health Organization is designing a plan to address the workforce shortage in order to achieve treatment on demand and maintain delivery of high quality services.

[45] Workforce Shortage Survey, King County Department of Community and Human Services, September 28 through November 2, 2015

- Opiate Treatment in Jail
  Current Implementation and Planning: Currently, individuals stable on methadone for treatment of opioid use disorder, who are booked into a King County jail facility (King County Correctional Facility or Norm Maleng Regional Justice Center), are continued on methadone treatment during incarceration. However, this is not a policy practiced by municipal jails in King County (for example, Kent Jail; Issaquah Jail; Enumclaw Jail; Kirkland Jail; or South Correctional Entity, SCORE), and represents a significant equity issue. The Task Force has identified representatives to address this issue from a policy standpoint. Currently, individuals stabilized on buprenorphine treatment will not be continued on buprenorphine during incarceration at any of the jails in King County (county or municipal). A design team has been established by Public Health - Seattle & King County, Jail Health Services to determine feasibility of providing buprenorphine induction and maintenance services to individuals incarcerated in the King County jail. The first phase of implementation will focus on developing a plan to provide buprenorphine maintenance services to individuals that present to jail stable on buprenorphine. The second phase of implementation will focus on developing a plan to provide buprenorphine induction services to incarcerated individuals in need of opiate treatment. To inform implementation efforts, the design team is currently examining the number of individuals booked into the King County jail who are stable on buprenorphine treatment for opioid use disorder.

Attachment L
PROPOSED NEIGHBOR RELATIONS PLAN

Molly Carney, Executive Director at Evergreen Treatment Services

Opiate treatment programs and other locations providing care for individuals experiencing opioid use disorder (for example, syringe exchange programs, community health engagement locations for persons with substance use disorders) should consider the following practices to establish and maintain good neighbor relations.

Clearly articulated hours and rules of business: For facilities where medication is being dispensed, hours of dispensing should be publicly available and followed. Any terms that clients must abide by should be readily available to the neighbors and the public.

Public Safety staff: Public Safety staff should be employed by the facility who are to be active during the dispensing hours. These staff should be specially trained in how to work with individuals experiencing opioid use disorder, mental health issues, and trauma histories. These staff should also be specially trained to work with clientele varying in age, race, ethnicity, gender, sexual orientation, primary language, and cognitive ability.

Numbers: There should be sufficient Public Safety staff to lend order inside and outside of the facility to at least the organization's property line (where authority is explicit) or to nearby manageable landmarks (for example, an intersection). Inside, Public Safety will help the clinic staff maintain any Code of Conduct or admission criteria established by the business. Outside, the staff will be attending to issues of loitering, dealing, or behavior that interferes with the neighboring businesses (for example, shoplifting).

MOU: Businesses adjacent to the target business may be encouraged to enter into a Memorandum of Understanding (MOU) which is intended to help facilitate communication between the entities. This MOU may permit the target business to allow their Public Safety staff to patrol the business property. The MOU should be reviewed and renewed on an annual basis.

Monthly rounds to business neighbors: Public Safety staff should make rounds to business owners or their managers on at least a monthly basis. Inquiries should be made regarding what's working well, what could be improved and/or escalation information if necessary (for example, who to contact if a business manager desires to escalate a complaint upward). These staff shall summarize their monthly rounds in a written document that is to be circulated to the executives and operation managers of the target business and a review team member who is a client that represents the intervention population. This summary shall include recommendations for how to rectify any complaints or problems. The target business shall be expected to help the Public Safety staff address or resolve complaints or problems within one week of the original complaint and shall include either a written response to the business owner/manager or a return visit by the Public Safety staff with the proposed resolution. The target business may consider implementing a monthly newsletter to neighboring businesses, which summarizes clinical outcomes (for educational purposes) and the response to neighborhood issues.

Attachment M
IMPLEMENTATION AND PLANNING DETAILS
Treatment Workgroup Recommendation 3
Mark Cooke, Policy Director at American Civil Liberties Union

Members of the Task Force participating in the policy workgroup have analyzed the challenge presented by local jurisdictions that make it difficult for MAT service providers to open facilities. The following legal analysis describes the legality of MAT program facilities in the state of Washington, common challenges in opening MAT facilities, and options to ease restrictions on opening MAT facilities. The legal analysis primarily focuses on methadone clinics, but similar circumstances exist in the siting of mental health and chemical dependency treatment facilities generally, and facilities providing other supportive services (for example, needle exchange facilities, community health engagement locations for persons with substance use disorders, etc.).

The Legality of MAT Program Facilities in Washington State

MAT facilities like methadone clinics are regulated by the federal government (21 U.S.C. §823; 42 CFR Part 8) and by Washington state (RCW 71.24.585 et seq.; WAC 388-877 and 388-877B). Clinics are considered "essential public facilities" and cannot be banned outright (RCW 71.24.590 (1)(b), RCW 36.70A.200). The Department of Social and Health Services is also tasked with consulting with local jurisdictions where a MAT service provider hopes to locate and to consider the need of treatment in the area. Approximately 25 clinics currently operate in Washington.[46]

Federal courts have ruled that clinic participants are legally designated as disabled and protected by the federal Americans with Disabilities Act, and that local governments cannot discriminate against clinics. *MX Group Inc. v. City of Covington*, 293 F.3d 326, (6th Cir. 2002); *Bay Area Addiction Research and Treatment v. City of Antioch*, 179 F.3d 725 (9th Cir. 1999).

Common Challenges in Opening MAT Facilities

Despite the heavy regulation of MAT facilities and a state law that requires local jurisdictions to provide permitted locations for their operation, many facilities never open. Here is a common scenario:

[46] DSHS – Appendix Q - Opiate Substitution Treatment Programs in Washington State, available at page 244 https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Cert%20%26%20LIcensing/Directory%20of%20Certified%20CD%20Svcs.pdf

A MAT service provider seeks to open a new facility in a local jurisdiction, identifies a suitable location (most frequently a building currently zoned for healthcare services), and the service provider seeks a permit from the jurisdiction to begin operations. During this process DSHS should be performing its duties to notify the local government about the facility and demonstrating the need for it (pursuant to RCW 71.24.590 (1). The local jurisdiction objects to the opening of the MAT facility and utilizes various regulatory procedures to slow the process. These obstacles could come in the form of requiring conditional or special use permits (allowed under RCW 71.24.590 (1)(b)) or by issuing a moratorium on MAT facilities. This can significantly slow things down and ultimately force the MAT provider to stop pursuing the facility, especially if there are pending financial or real estate transactions contingent on obtaining permits in a timely fashion.

Media accounts illustrate this problem:

- Puyallup – *Tacoma News Tribune* – "Clinic hopes to offer methadone treatment in Puyallup; city not yet sure," December 2016, available at http://www.thenewstribune.com/news/local/article48078615.html
- Bremerton – *Kitsap Sun* – "Bremerton council to consider moratorium on methadone treatment facilities," July 2011, available at http://www.kitsapsun.com/news/local/bremerton-council-to-consider-moratorium-on-methadone-treatment-facilities-ep-418347397-357153961.html
- Lynnwood – *The Seattle Times* – "Methadone-treatment company sues Lynnwood over clinic plans," February 2003, available at http://community.seattletimes.nwsource.com/archive/?date=20030212&slug=methadone12n0

Options to Ease Restrictions on Opening MAT Facilities

Amend State Law

RCW 71.24.590 could be amended to make the siting of MAT facilities easier. Currently, DSHS make a determination of need and local jurisdictions can require onerous conditional or special use permits, as well as moratoriums. Due to the emergent nature of the opiate epidemic and statewide need for treatment, the DSHS need process may be unnecessary at this point. The legislature could also remove local jurisdictions' ability to require special permits and require that MAT facilities be treated like any other healthcare facility.

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28. BOH Resolution 07-07, adopting recommendations of the BOH HIV/AIDS Committee, September 20, 2007, available at http://www.kingcounty.gov/depts/health/board-of-health/~/media/depts/health/board-of-health/documents/resolutions/res0707.ashx

Attachment P

WORLD OVERVIEW OF SUPERVISED CONSUMPTION SITES

World overview of drug consumption rooms

Country	DCR	Eligibility and services	Client profiles	Results
Australia	**Location** 1 in Sydney **Staff** 1 in injecting room Training: At least 1 nurse, 3 officers with health training	**Eligibility** 18 years and over Already drug dependent Not pregnant nor with child Not intoxicated No dealing of drugs on premises **Services** Stage 1: Waiting room/assessment area Stage 2: Injecting room with 8 booths Stage 3: After care room Resuscitation room Links to health, legal, housing, welfare services	12,050 clients between May 2001 and April 2010 3 new clients a day on average 74% men / 26% women 33 years of age on average 13 years of average time injecting Principal substances used Drop in heroin use (40% in 2005) Increase in other opioid use (60% in 2012) Decline in cocaine use (15% in 2012) 10% methamphetamines 1-2% buprenorphine	Cost-effective Contacts vulnerable groups – 9,500 referrals to health and social welfare services 4,400 overdose interventions (no fatalities) Reduced risk of blood-borne virus transmission Reduced public injecting and injection-related litter No adverse impact on local community (e.g. increase in drug-related crime in area)
Canada	**Location** 1 in Vancouver called 'Insite' **Staff** 9 staff Training: nurses, programme workers (PHS), peer support workers	**Eligibility** No admission criteria **Services** Low-threshold, anonymous service with 12 drug consumption booths Supply of clean injection equipment and safer use counselling Primary healthcare services Voluntary detox (Onsite) Links to longer-term drug dependence treatment programmes Links to housing and community support	1.8 million visitors since 2003 Between 1st Jan 2010- 31st Dec 2010: 312,214 visits by 12,236 clients 855 average daily visits 587 average daily injections 74% men / 26% women 17% identified as Aboriginal Principal substances used 36% heroin 32% cocaine 12% morphine	221 overdose interventions (no fatalities) 3.383 clinical treatment interventions 5,268 referrals to other social and health services 458 admissions to Onsite detox programme (completion rate in 2010: 43%) Reduced risk of blood-borne virus transmission Reduced public injecting and injecting-related litter No adverse impact on local community
Germany	**Location** 26 in 17 cities country-wide **Staff** Number of staff variable according to size of DCR and financial constraints Training: Doctors, nurses, educators, qualified student assistants and freelancers	**Eligibility** Age eligibility varies according to state regulation Already drug dependent Not under OST (except in Hamburg) Not intoxicated **Services** DCRs integrated with harm reduction facilities Open between 3.5 and 12 hours a day 3 to 20 drug consumption booths Links to medical and social services	In Frankfurt[9] from 2003 to 2009: Up to 4,700 visitors per year 26-35 years of age on average 85% men / 15% women Principal substances used 82% heroin 36% crack[10]	Since 1994, no drug-related deaths recorded in Germany Increased client awareness of safer use techniques Less drug-related health problems (e.g. fewer abscesses) Data from North Rhine Westphalia (2001-2009): 3,271 drug emergency cases 710 CPRs
Luxembourg	**Location** 1 in the City of Luxembourg called 'Abrigado' **Staff** 23 multilingual staff Training: Medical staff, psychologists social workers, educators, sociologists	**Eligibility** 18 years and over Already drug dependent Not under OST Not pregnant or with child Not intoxicated No dealing of drugs on premises Sign a 'terms of use' contract **Services** Integrated in low-threshold centre with 7 injection booths Pilot project 'Blow room' with 3 inhalation booths Open 6 days a week, 6h a day) Night shelter (42 beds) and nursery Drop-in centre (Kontakt Café) with primary medical care On-site HIV/hepatitis C testing Needle exchange programme Safer use counselling	170,000 supervised drug consumptions (since 2005) 26,929 visits to DCR in 2011 207 average visitors per day (Kontact Café) 96 average visitors per day (DCR) 25-34 years of age on average 80% men / 20% women Principal substances used 87% heroin 8% cocaine 5% mixtures	1,025 overdoses successfully managed (no fatalities) General decrease in overdose deaths and proportion of people who inject drugs in newly diagnosed HIV infection cases since the opening of the DCR Citizens hotline established to encourage public acceptance of DCR A few complaints from neighbouring communities recorded

Country	DCR	Eligibility and services	Client profiles	Results
The Netherlands	**Location** 37 in 25 cities country-wide **Staff** 3 staff members Training: Medical staff, social workers, former drug users, security staff	**Eligibility** Registered in city where DCR is located Sign a 'terms of use' contract No dealing of drugs on premises Different admission criteria according to each DCR **Services** 5 'stand-alone' DCRs, others are integrated within low-threshold services Separate rooms for injectors and smokers 15 booths for smokers, 5 for injectors Medical and safer use counselling	24 clients per day on average 90% clients are non-injectors 45 years of age on average[11] 90% men / 10% women[12] Principal Substances used[13] Heroin Crack/coke base	Decrease in needle sharing Only 4% of new diagnoses of HIV, Hepatitis B and C among people who use drugs HIV incidence rates among people who inject drugs dropped from 8.6% in 1986 to 0% in 2000 94 acute drug-related deaths in 2010 with 20 non-municipal registered people Significant decrease in public disturbance High acceptance of DCRs (80%) by social/health providers, neighbourhoods and police
Norway	**Location** 1 in Oslo **Staff** Minimum of 5 staff on duty during opening hours, including at least 1 nurse. Training: Nurses, auxiliary nurses and social workers	**Eligibility** Heroin only substance allowed 18 years and over Sign a 'terms of use' contract Long term history of injecting heroin **Services** Limited to one dose of heroin per client per visit Integrated with harm reduction services Links with social and health services Links to drug dependence treatment programmes	2,480 registered clients since 2005 1,500 clients per year 109 clients per day on average (2011) 37 years of age on average 70% men / 30% women Principal substances used Heroin is the only substance allowed to be used in the DCR	Reduced perception of social exclusion among the user group Increased access to professional assistance in overdose situations Increased access to health and social services
Spain	**Location** 7 in 4 cities country-wide, including 1 mobile DCR **Staff** Number of staff variable according to each DCR Training: multidisciplinary, with at least 1 nurse	**Eligibility** 18 years and over Sign a 'terms of use' contract (in the Barcelona DCRs) **Services** 3 DCRs allow smoking Links to social and health services Links to drug dependence treatment programmes In Barcelona: HIV testing and counselling, health care and social, psychological and legal support	105,804 visits from 5.063 clients (2009) 34 years of age on average 80% men / 20% women Principal substances used Cocaine most popular (except in Bilbao and Sala Balaurd in Barcelona, 2009) Heroin most popular (Barcelona, 2011) Speedball most popular (Madrid, 2011)	Decrease in overdose deaths from 1,833 in 1991 to 773 in 2008 Decrease in new HIV infections among clients from 19.9% in 2004 to 8.2% in 2008 High acceptance and demand for DCRs Reduced injection-related litter in public spaces Community awareness about DCRs as a public health strategy Development of common guidelines on harm reduction and DCRs
Switzerland	**Location** 13 in 8 cities country-wide **Staff** No country-wide data In Berne: Training: nurses and social workers.	**Eligibility** 18 years and over Already drug dependent Have official documentation No dealing of drugs on premises No consumption tolerated outside the DCR itself (e.g. cafeteria, toilets) **Services** Booths for intravenous use, smoking and sniffing (numbers vary according to the DCR) Cafeteria with food and non-alcoholic beverages Medical treatment Consultations for social problems Hygiene services (showers, provision of clothes) NSP Links to drug dependence treatment programmes and clinics	No country-wide data In Berne: 38 years of age on average 992 registered clients a year 200 clients a day 74.1% men / 25.9% women Principal Substances No country-wide data In Berne: Heroin Cocaine Benzodiazepines Cannabis Substitutes Alcohol	Decrease in drug-related deaths Increased client awareness of safer use techniques Reduces risk of blood-borne virus transmission

Source: Schatz, E. and Nougier, M. IDPC Briefing Paper: Drug consumption rooms, evidence and practice (June 2012).

Attachment Q

LEGAL FRAMEWORK GRID

Mark Cooke, Policy Director at American Civil Liberties Union

Governing and Operating Structure	Legal Authority/State and Federal Conflicts	Insurance Options	Onsite Smoking	Healthcare Professional Liability
Public Health - Seattle & King County (PHSKC) in collaboration with King County Department of Community and Human Services (DCHS) governs and operates the CHEL site.	A CHEL site governed and operated by the public health authority would be in a strong legal position under state law, including protections against the prosecution of state criminal laws. No such protection would exist against the prosecution of federal criminal laws, but having a government run program would likely be a good political position to advocate against federal interference.	CHEL site would likely fall under King County's self-insurance pool, which covers up to $6.5million. Could also obtain a reinsurance policy on the private market for overages.	Use of smoked or vaped tobacco products at a CHEL site may violate RCW 70.160 and KC BOH 19.03. The law is not as clear for the act of inhalation of cocaine, meth, or heroin, which is technically more akin to "vaping" than "smoking."	Government employees of a SCS would likely be insured to the same extent as the facility, up to $6.5 million. The self-insurance also applies to professional licensing matters. Reinsurance for greater losses would be challenging to procure.
A public-private partnership between PHSKC/DCHS and other community-based service providers, in which PHSKC/DCHS authorizes the CHEL site and contracts with a service provider to operate it.	A CHEL site governed by the public health authority and operated by a community-based service provider via a contract would be in a strong legal position under state law, including protections against the prosecution of state criminal laws.	May fall under King County's self-insurance pool, which covers up to $6.5million, if an agency relationship between the county and provider is established. Could obtain coverage on the private secondary	Use of smoked or vaped tobacco products at a CHEL site may violate RCW 70.160 and KC BOH 19.03. The law is not as clear for the act of inhalation of cocaine, meth, or heroin, which is	Government "agents" would likely be insured to the same extent as the facility, including professional licensing matters. Otherwise, private insurance would be needed.

Governing and Operating Structure	Legal Authority/State and Federal Conflicts	Insurance Options	Onsite Smoking	Healthcare Professional Liability
	No such protection would exist against the prosecution of federal criminal laws, but having the program governed by public health authority would likely be a good political position to advocate against federal interference.	market (ex. Lloyds of London).	technically more akin to “vaping” than “smoking.”	
PHSKC/DCHS or local ordinance provides oversight of CHEL site via some sort of regulatory or permitting process, in which private community-based service providers determine independently whether to operate a CHEL site.	The strength of the CHEL site legal position under state law will depend on the nature of the government oversight of the CHEL site. If it’s the public health authority that creates and enforces the regulatory process for CHEL site permitting, then it’s possible that the legal protections for public health authorities could extend to the private community-based service providers. If the government oversight comes in the form of a local ordinance via a legislative body, not relying on public health authority, the legal protection would not be as	Could obtain coverage on the private secondary market (ex. Lloyds of London). Obtaining private insurance could also be a mandate of government regulation of a CHEL site.	Use of smoked or vaped tobacco products at a CHEL site may violate RCW 70.160 and KC BOH 19.03. The law is not as clear for the act of inhalation of cocaine, meth, or heroin, which is technically more akin to “vaping” than “smoking.”	Employees would need to find insurance via the secondary market.

Governing and Operating Structure	Legal Authority/State and Federal Conflicts	Insurance Options	Onsite Smoking	Healthcare Professional Liability
	robust. However, this is still a feasible option if local prosecutors decide to exercise discretion, allowing the CHEL site to operate, even if it's technically violating state criminal law. No protection would exist against the prosecution of federal criminal laws, but having some form of government oversight might help in making political arguments against federal interference.			
No changes to existing law, private community-based service providers start operating a CHEL site	Opening a private CHEL site under existing law would be in a relatively weak legal position. However, the community-based service provider could point to the 2007 King County Board of Health resolution that recommended the creation of a CHEL site as an indication that this type of program is a legitimate	Could obtain coverage on the private secondary market (ex. Lloyds of London).	Use of smoked or vaped tobacco products at a CHEL site may violate RCW 70.160 and KC BOH 19.03. The law is not as clear for the act of inhalation of cocaine, meth, or heroin, which is technically more akin to "vaping"	Employees would need to find insurance via the secondary market.

Governing and Operating Structure	Legal Authority/State and Federal Conflicts	Insurance Options	Onsite Smoking	Healthcare Professional Liability
	public health intervention.[47] Operating under the authority of public health or via local ordinance may also be unnecessary if local prosecutors decide to exercise discretion, allowing the CHEL site to operate, even if it's technically violating state criminal law. No protection would exist against the prosecution of federal criminal laws, but policy arguments could be made for why the federal government should not get involved in a local public health matter.		than "smoking."	

[47]BOH Resolution 07-07, adopting recommendations of the BOH HIV/AIDS Committee, September 20, 2007, available at http://www.kingcounty.gov/depts/health/board-of-health/~/media/depts/health/board-of-health/documents/resolutions/res0707.ashx

Attachment R
SUMMARY OF LEGAL CONSIDERATIONS FOR COMMUNITY HEALTH ENGAGEMENT LOCATIONS FOR INDIVUALS WITH SUBSTANCE USE DISORDERS (CHEL sites) WHERE SUPERVISED CONSUMPTION OCCURS IN KING COUNTY

Mark Cooke, Policy Director at American Civil Liberties Union

The King County and Seattle Task Force on Heroin and Prescription Opiate Addiction is considering a recommendation to create Community Health Engagement Locations for individuals with substance use disorders (CHEL sites) where supervised consumption occurs (also known as Supervised Consumption Sites) in order to reduce drug-related health risks and harms, including overdose deaths, transmission of HIV and hepatitis B and C viruses, and drug-associated adverse health effects. These sites could also provide access to substance use disorder treatment and related health and social services; reduce impact of drug use in public spaces; provide a safe and trusting environment where individuals using drugs can engage with services to improve their health; and reduce participant engagement with the criminal justice system. Such a recommendation would not be unprecedented. In 2007, the Board of Health of King County adopted a resolution that recommended a CHEL site for purposes of HIV prevention.[48] Despite this formal acknowledgement that a CHEL site is a viable public health intervention, no such facility opened.

Due to the fact that most of the drugs consumed in a CHEL site will be obtained illicitly and are controlled substances, there are many questions about the legality of such facilities.[49] The following analysis provides background information on some of the legal issues that could arise in the creation and operation of a CHEL site.

A CHEL site Likely Fits Within the Legal Authority of a Local Board of Health and Local Health Officer

Under Washington State law, a local board of health is given broad authority to preserve "the life and health of people within its jurisdiction."[50] This authority is derived from the state legislature and Washington Constitution.[51] For purposes of a CHEL site, several of the local board of health's affirmative responsibilities are relevant. These include the board's duty to:

- Enact such local rules and regulations as are necessary in order to preserve, promote and improve the public health and provide for the enforcement thereof;

[48] BOH Resolution 07-07, adopting recommendations of the BOH HIV/AIDS Committee, September 20, 2007, available at http://www.kingcounty.gov/depts/health/board-of-health/~/media/depts/health/board-of-health/documents/resolutions/res0707.ashx

[49] For a more in depth analysis on the legality of SCS type facilities see – Beletsky, et al. The Law (and Politics) of Safe Injection Facilities in the United States, *American Journal of Public Health*, 2008 February; 98(2): 231-237, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2376869/

[50] RCW 70.05.060, available at http://app.leg.wa.gov/RCW/default.aspx?cite=70.05.060

[51] Washington Constitution, Article 11 Sec. 11 – "Any county, city, town or township may make and enforce within its limits all such local police, sanitary and other regulations as are not in conflict with general laws."

- Provide for the control and prevention of any dangerous, contagious or infectious disease within the jurisdiction of the local health department;
- Provide for the prevention, control and abatement of nuisances detrimental to the public health.[52]

Similarly, a local health officer, under the direction of the local board of health, is given broad authority to enforce public health laws.[53] Several of the local health officer's responsibilities are relevant for purposes of creating and operating a CHEL site, including his or her duties to:

- Control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his or her jurisdiction;
- Inform the public as to the causes, nature, and prevention of disease and disability and the preservation, promotion and improvement of health within his or her jurisdiction;
- Prevent, control or abate nuisances which are detrimental to the public health.[54]

A CHEL site fulfills several of the public health aims listed above. By consuming drugs in a clean environment and providing individuals using drugs with sterile equipment, the spread of diseases such as HIV and hepatitis will be reduced. The board or health officer could also argue that a CHEL site is a method to control and prevent the "dangerous…disease" of severe substance use disorders and that a CHEL site is a gateway into treatment.[55] A CHEL site could also improve community public health by limiting the amount of public drug use and discarded drug equipment, which could be viewed as a form of nuisance abatement.

The legality of a CHEL site and the role of public health authority could also be impacted by the governing structure of the program. The task force has discussed three types of structures with varying degrees of Public Health – Seattle & King County (PHSKC)/Department of Community and Human Services (DCHS) involvement, and a fourth option is if a private CHEL site opens without any government oversight:

A) Public Health - Seattle & King County (PHSKC) in collaboration with King County Department of Community and Human Services (DCHS), and/or;

B) A public-private partnership between PHSKC/DCHS and other community-based service providers, and/or;

C) Another entity with oversight by PHSKC/DCHS;

D) Private entity opens CHEL site with no PHSKC/DCHS oversight.

Arguably, the public health authority described above would be applicable in the first three contexts, although it would be most straightforward if PHSKC/DCHS was in charge of governing

[52] Id.
[53] RCW 70.05.070, available at http://app.leg.wa.gov/RCW/default.aspx?cite=70.05.070
[54] Id.
[55] See American Psychiatric Publishing – Substance-Related and Addictive Disorders, 2013, available at http://www.dsm5.org/documents/substance%20use%20disorder%20fact%20sheet.pdf

and operating the CHEL site (options A and B). This structure would make it quite obvious that public health authorizes the CHEL site for legitimate public health reasons. However, even if public health authorities plays more of an oversight role as in option C, it also seems like public health authority should be recognized and extend some protections to third party actors, since they are acting with the agencies' approval to advance public health.

Impact of State Criminal Drug Laws

Washington's Uniform Controlled Substances Act criminalizes the possession of many of the controlled substances that would be consumed in a CHEL site and could be applicable in other contexts such as paraphernalia, maintaining a building where people consume controlled substances, and civil asset forfeiture.[56] Although the Task Force can recommend that the state legislature make changes to these laws, they cannot change them on their own; therefore conflicting legal interests must be balanced. In this instance, how do state criminal laws interact with broad public health authority? Existing programs and laws already operating in Seattle and King County provide useful comparisons for legal frameworks.

Needle Exchange Programs

Washington and Seattle/King County have been national leaders in adopting needle exchange programs, which have proven to be an incredibly effective public health intervention for reducing the spread of infectious diseases.[57] When these programs originated in the late 1980's, legal questions were posed that are similar to those CHEL site's face currently. For example, some prosecutors argued that these programs illicitly distributed drug paraphernalia. In Washington State, this legal question was eventually answered in a state Supreme Court case – *Spokane County Health District v. Brockett* (1992).[58]

In *Brockett,* the Spokane County Prosecutor, Spokane Sheriff, and State Attorney General challenged a Spokane County Health District Board of Health resolution, which directed the health officer to "to establish and implement a needle exchange program in Spokane as a part of an overall intervention to slow the spread of AIDS and other infectious diseases among IVDUs and those with whom they come into contact." The recommendation to operate a needle exchange program was made after careful deliberation by the board of health about the need for the intervention. In ruling in favor of the needle exchange the court in *Brockett* stated that, "the broad powers given local health boards and officers under Const. art. 11, § 11 and RCW 70.05 authorize them to institute needle exchange programs in an effort to stop the spread of HIV and AIDS," despite the fact that they were distributing drug paraphernalia.

[56] RCW 69.50 et seq., available at http://app.leg.wa.gov/RCW/default.aspx?cite=69.50
[57] See Public Health – Seattle & King County Needle Exchange Program, available at http://www.kingcounty.gov/healthservices/health/communicable/hiv/resources/aboutnx.aspx
[58] *Spokane County Health District v. Brockett*, 120 Wn.2d 140, P.2d 324, November 5, 1992, available at http://courts.mrsc.org/supreme/120wn2d/120wn2d0140.htm.

Just as Washington was facing an HIV/AIDS epidemic in the 1980's, we now face an opioid epidemic.[59] A decision by a board of health and/or local health officer to "establish and implement" a CHEL site in an effort to prevent overdoses and the spread of infectious diseases seems squarely within the public health authority at issue in the needle exchange context ruled on in *Brockett*.

Prosecutorial Discretion, LEAD Program, and Law Enforcement Prioritization

Another crucial component of a successful CHEL site will be to work with law enforcement in an honest and transparent manner. It will take discretion by police and prosecutors to not target the clients of CHEL sites for the intervention to succeed. Even if public health authority sanctions a CHEL site, that protection will not spread beyond the walls of the facility, so clients will need some assurances that they will not be targeted when coming and going. Fortunately, this type of law enforcement discretion and prioritization is not uncommon and Seattle/King County is again national leaders. For example, needle exchange programs would not have flourished here without tacit support by police and prosecutors. More recently, the Law Enforcement Assisted Diversion program (LEAD) began operating in Seattle and King County.[60] This program diverts low-level drug and prostitution cases to harm reduction focused case management services at the point of arrest, instead of a booking into jail and criminal charge. The legal basis for LEAD stems from the discretion of police who choose whether someone is eligible and from the prosecutor who chooses not to file a criminal case.

The law around this type of legal discretion is clear. For prosecutors, as stated by the U.S. Supreme Court, "the decision to file criminal charges, with the awesome consequences it entails, requires consideration of a wide range of factors ***in addition to the strength of the Government's case***, in order to determine ***whether prosecution would be in the public interest. Prosecutors often need more information than proof of a suspect's guilt***, therefore, before deciding whether to seek an indictment."[61] A strong case can be made that allowing a CHEL site to operate without interference from law enforcement is in the public interest.

Similarly, this type of discretion can be codified in the form of lowest law enforcement priority laws. Seattle passed such a law in 2003 in the marijuana context, which states that the "Seattle Police Department and City Attorney's Office shall make the investigation, arrest and prosecution of marijuana offenses, where the marijuana was intended for adult personal use, the City's lowest law enforcement priority."[62] Although this type of codified law is likely not necessary for a CHEL site to operate, it shows that discretion and prioritization are an everyday part of life for law enforcement.

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[59] U.S. Department of Health & Human Services – About the Epidemic, available at http://www.hhs.gov/opioids/about-the-epidemic/index.html
[60] See – www.leadkingcounty.org
[61] *United States v. Lovasco*, 431 U.S. 783
[62] SMC 12A.20.060, available at https://www2.municode.com/library/wa/seattle/codes/municipal_code?nodeId=TIT12ACRCO_SUBTITLE_ICRCO_CH12A.20COSU_12A.20.060ENPRAR

911 Good Samaritan and Naloxone Laws

Two state laws that could potentially be helpful in the operation of a CHEL site are the 911 Good Samaritan and naloxone access laws.[63] Washington's Good Samaritan law, which passed in 2010, provides legal protection against drug possession charges for people who seek medical assistance during an overdose. This protection extends to the people who seek medical help as well as the person suffering from the overdose. The law also contains strong intent language – "the legislature intends to save lives by increasing timely medical attention to drug overdose victims through the establishment of limited immunity from prosecution for people who seek medical assistance in a drug overdose situation."[64] Taken together, the legal protection could help insulate CHEL site employees and clients from drug possession charges in the event of an overdose at the facility and the intent language indicates that the state has an interest in preventing overdose deaths via means beyond the enforcement of criminal laws.

Similarly, Washington's naloxone access law, originally passed in 2010 with significant amendments in 2015, shows that public health approaches are welcomed by the state legislature. The intent of this law is "to increase access to opioid overdose medications…and to permit those individuals to possess and administer opioid overdose medications prescribed by an authorized health care provider."[65] A CHEL site would be an ideal place to have naloxone on site and to distribute it to an at-risk population.

Impact of Federal Criminal Drug Laws

Similar to Washington State law, the federal government criminalizes activity that is likely to occur at a CHEL site, such as drug possession or maintaining a drug-involved premises, and the task force cannot change federal law.[66] Nonetheless, a strong case can be made that a CHEL site can lawfully exist parallel to federal prohibition, especially at a time when the federal government, like Seattle/King County, is trying to end the opiate epidemic.[67] However, it should be noted that it would ultimately be up to federal law enforcement to decide whether to enforce its own laws against a CHEL site. In examining this apparent conflict, other state/federal drug policy disconnects are worth considering.

An important consideration to keep in mind when looking at the intersection of federal and state drug policy is that the vast majority of drug law enforcement is conducted at the state and local level. In 2010, there were 27,200 federal drug arrests across the U.S, out of a total 1,638,846 drug arrests by all federal, state, and local agencies, which means over 98% of drug arrests are

[63] RCW 69.50.315, available at http://app.leg.wa.gov/RCW/default.aspx?cite=69.50.315 and RCW 69.41.095, available at http://app.leg.wa.gov/RCW/default.aspx?cite=69.41.095
[64] RCW 69.50.315, available at http://app.leg.wa.gov/RCW/default.aspx?cite=69.50.315
[65] http://app.leg.wa.gov/RCW/default.aspx?cite=69.41.095
[66] 21 USC Secs. 844 and 856
[67] The White House – Fact Sheet: Obama Administration Announces Additional Actions to Address the Prescription Opioid Abuse and Heroin Epidemic, March 2016, available at https://www.whitehouse.gov/the-press-office/2016/03/29/fact-sheet-obama-administration-announces-additional-actions-address

conducted at the state and local level.[68] Federal law enforcement has also stated publicly that it must make choices about where to commit scarce resources, and that some low-level drug possession cases, such as for marijuana, are not worth pursuing, especially when state or local governments have strong and effective regulatory and enforcement systems in place.[69] This decision is obviously not the Task Force's to make, but it's apparent that just because an activity is illegal at the federal level doesn't mean that a state or local government must have an identical law. The clearest example of this is the fact that 24 states have medical marijuana laws and 4 states and Washington D.C. have marijuana legalization and regulation laws, despite continued federal prohibition of marijuana.[70] Needle exchanges are also not officially allowed by the federal government, yet they operate in 38 states, and the federal government's funding ban was recently eased.[71]

Similarly, arguments can be made that certain federal crimes are not intended to be applicable in the CHEL site context. For example, the actions that give rise to the "Maintaining drug-involved premises" crime may be technically present at a CHEL site, since individuals will be "using controlled substances" in a "place" managed or controlled by the CHEL site operators. But, this crime was intended to focus on illicit enterprises, while a CHEL site is a public health intervention aimed at saving lives and getting people into treatment. Ultimately, it would be up to federal prosecutors to make the decision of whether to bring charges for this type of crime, but they are not required to do so.

Some might also argue that a locally authorized CHEL site would be federally preempted. This specific legal question has not been answered in any U.S. court, but similar issues have been emerging in the marijuana context and the answer is by no means definitive that a more liberal drug policy at state or local level would be preempted by federal law.[72] First, the federal government cannot force a state or local government to criminalize any type of drug activity.[73] Second, the Supreme Court has been very deferential to the traditional police powers of the states. In ruling in favor of the State of Oregon in the physician-assisted suicide context, the Court noted that the "structure and limitations of federalism … allow the States great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons" (internal quotation omitted).[74] As noted above, local public health authority in Washington is derived from the state Constitution and the legislature, so it's likely this deference would also be extended to local authorities in the CHEL site context.

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[68] See – US Census – Table 328 - https://www.census.gov/prod/2011pubs/12statab/law.pdf and FBI UCR 2010- https://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/tables/10tbl29.xls

[69] See – Cole Memorandum, August 29, 2013 – Guidance Regarding Marijuana Enforcement – pg. 2, available at https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf

[70] See – National Conference of State Legislatures – State Medical Marijuana Laws, available at http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx

[71] Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016, available at https://www.aids.gov/pdf/hhs-ssp-guidance.pdf

[72] *County of San Diego v. San Diego NORML*, 165 Cal. App. 4th 798, 81 Cal. Rptr. 3d 461 (2008)

[73] See – Chemerinsky – *LA Times*, "On pot laws, respect the states - http://articles.latimes.com/2013/mar/27/opinion/la-oe-chemerinsky-marijuana-legalization-20130327

[74] *Gonzales v. Oregon*, 546 U.S. 243, 270, 126 S. Ct. 904, 163 L. Ed. 2d 748 (2006).

Conclusion

If the King County Board of Health and the local public health officer adopt resolutions to establish and implement a CHEL site, they would be in a strong legal position, despite existing state and federal criminal drug laws. It's also possible that these legal protections would exist if local legislative bodies set up a regulatory system that allows private actors to operate a CHEL site, but the outcome is less clear. Nonetheless, just as important as the legal considerations are political ones. For this reason the Task Force should continue to deliberate the need for a CHEL site in an open and collaborative manner.

Attachment S

Key Potential Opportunities for Washington and King County in S. 524, the Comprehensive Addiction and Recovery Act of 2016 (CARA)

Full text at: https://www.congress.gov/114/bills/s524/BILLS-114s524enr.xml

Chris Verschuyl, Department of Community and Human Services

The grant programs described below, authorized by the CARA legislation, are subject to appropriation. As noted the President's July 22, 2016 signing statement, ***no funding had yet been appropriated at the time of this analysis****. This analysis also includes key policy changes that are not dependent on funding.*

Analysis of Key Sections of CARA [75]

Implement Comprehensive Community-Wide Strategies (Section 103)
$5M/year ($25M total) Federal Fiscal Year (FFY) 2017-2021, if appropriated.

Grants to organizations funded under the Drug-Free Communities Act of 1997 (most often community coalitions), with documented sudden increases in opiate use or significantly higher rates of opiate use than the national average, to:

- Implement comprehensive community-wide strategies to address local drug crises.

Expand Access to Drugs or Devices for Opioid Overdose Reversal (Section 107)
$5M total for FFY 2017-2021, if appropriated.

Grants to federally qualified health centers, opioid treatment programs, or any other entity deemed appropriate by HHS, to:

- establish a program for prescribing a drug or device for overdose reversal
- train and provide resources for health care providers and pharmacists regarding prescribing overdose reversal drugs and devices
- purchase overdose reversal drugs or devices
- establish protocols to connect patients who have experienced overdose with appropriate treatment

Opioid Overdose Reversal Medication Access and Education (Section 110)
$5M total for FFY 2017-2019, if appropriated.

Grants to states that have authorized standing orders to be issued for overdose reversal drugs or devices,[76] in order to:

- implement strategies for pharmacists to dispense an opioid overdose reversal drug or device via standing orders

[75] See also a helpful section by section analysis of the entire CARA legislation, at http://nasadad.org/wp-content/uploads/2016/07/CARA-Section-by-Section-July-2016.pdf. The analysis in this document is informed by NASADAD's review, but focuses solely on programs, policies, and opportunities relevant to the state of Washington and King County. For example, most provisions relating to the Veterans Administration are excluded.

[76] In Washington, standing orders are explicitly permitted via ESHB 1671, passed by the state legislature in 2015.

- encourage pharmacies to dispense opioid overdose reversal medication via standing orders
- develop or provide training materials on the administration of an opioid overdose reversal drug or device
- educate the public about the availability of opioid overdose reversal drugs or devices

Comprehensive Opioid Abuse Grant Program (Section 201)
$103M/year ($515M total) for FFY 2017-2021, if appropriated.

Grants of up to 4 years to states, local governments, and tribes (that may not supplant state, local, or tribal funds), to:

- develop, implement or expand any of the following:
    - treatment alternative to incarceration programs, which can include:
        - prebooking or postbooking components
        - training for criminal justice agencies regarding behavioral health conditions
        - mental health court, drug court, and/or veterans' treatment court
        - focus on parents whose incarceration could result in children entering the child welfare system, and
        - community-based substance use diversion program sponsored by a law enforcement agency[77]
    - medication-assisted treatment (MAT)[78] programs used or operated by a criminal justice agency
    - prescription drug monitoring programs[79]
    - the use of technology to provide a secure container for prescription drugs
    - integrated and comprehensive opioid abuse response programs
- enhance planning and collaboration between state criminal justice and state substance abuse agencies to address opioid abuse[80]
- train first responders on carrying, administering, and purchasing opioid reversal drugs or devices
- locate or investigate illicit activities related to unlawful distribution of opioids

First Responder Training (Section 202)
$12M/year ($60M total) for FFY 2017-2021, if appropriated.

Grants to states, local governments, and tribes to allow first responders and other key community sectors to:

- administer an opioid overdose reversal drug or device
    - emphasis on evidence-based methodology, outcome evaluation, and broad replication

[77] This specific provision was added by Washington Rep. Suzan DelBene, who explicitly mentioned King County's Law Enforcement Assisted Diversion (LEAD) program as an example.
[78] In this legislation, MAT is defined as the use of FDA-approved medications in combination with counseling and behavioral therapies.
[79] This potential grant purpose would be available only to states, not local governments or tribes.
[80] This potential grant purpose would be available only to states, not local governments or tribes.

Expanded Disposal Sites for Unwanted Prescription Medications (Section 203)
No new funding authorization specific to this program.

Grants to state/local/tribal law enforcement agencies, prescription medication manufacturers or distributors, retail pharmacies, registered narcotic treatment programs, hospitals or clinics with onsite pharmacies, eligible long-term care facilities, or any other entity authorized by the DEA to dispose of prescription medications, to:

- expand or create disposal sites for unwanted prescription medications.

Evidence-based Prescription Opioid/Heroin Treatment and Interventions Demonstration (Section 301)
$25M/year ($125M total) for FFY 2017-2021, if appropriated.

Grants to state substance abuse agencies, units of local government, nonprofit organizations, and tribes that have a high rate or rapid increase in the use of opioids, to:

- expand the treatment of addiction, including expanding MAT,[81] in specific geographic areas affected by the high rate or rapid increase in opioid use, including rural areas

Building Communities of Recovery via Recovery Community Organizations (Section 302)
$1M/year ($5M total) for FFY 2017-2021, if appropriated.

Grants to recovery community organizations,[82] not to exceed half of program costs, to:

- develop, expand, and enhance recovery services, including recovery support services
- build connections with behavioral health and physical health care provider networks
- reduce stigma associated with substance use disorders (SUDs)
- conduct public education and outreach related to SUDs and recovery

Changes to Prescribing Rules for Buprenorphine (Section 303)

Makes certain revisions to the maximum number of patients per prescriber as follows:

- Maintains current maximum allowable caseload numbers (30 in first year and 100 thereafter), but permits HHS to change the maximum number by regulation
- Permits states to set lower maximum numbers, between 30 and the federally allowed maximum, or to add additional requirements for qualifying practitioners
- Excludes from any provider's maximum number any patients to whom buprenorphine is directly administered in the office setting

Changes the qualifications for providers who may prescribe buprenorphine, as follows:

- Includes nurse practitioners or physician assistants who:
    - are licensed to prescribe schedule III, IV, or V drugs for the treatment of pain;
    - have completed 24 hours of training in the treatment and management of opiate-dependent patients from national organizations deemed appropriate by HHS
    - are supervised by a qualifying physician

[81] In this legislation, MAT is defined as the use of FDA-approved medications in combination with counseling and behavioral therapies.
[82] Recovery community organizations are nonprofits that mobilize resources within and outside the recovery community to increase long-term recovery, and are principally governed by people in recovery who reflect the community served.

- Requires qualifying physicians to:
    - Hold a board certification in addiction psychiatry or addiction medicine from the American Board of Medical Specialties;
    - Hold an addiction certification or board certification from the American Society of Addiction Medicine or the American Board of Addiction Medicine
    - Requires physicians' 8 hours of training from national organizations deemed appropriate by HHS to include:
        - opioid maintenance and detoxification
        - appropriate clinical use of all drugs approved by the FDA
        - initial and periodic patient assessments (including substance abuse monitoring)
        - individualized treatment planning, overdose reversal, and relapse prevention
        - counseling and recovery support services
        - staffing roles and considerations
        - diversion control
        - other best practices

Changes to Residential Treatment for Pregnant and Postpartum Women (PPW) (Section 501)
$1M/year ($5M total) increase for FFY 2017-2021 over $15.9M/year FFY 2016 level, if appropriated. Up to 25% of the total authorized appropriation for PPW may be used for this pilot program (maximum of $4.2M/year, $21.1M total, if appropriated). However, the pilot program only moves forward if total PPW appropriation exceeds baseline level of $15.9M/year.

Reauthorization of SAMHSA's PPW grants to state substance abuse agencies includes the following changes:

- Prioritizes grants to programs serving rural areas, health professional shortage areas, and areas with a shortage of family-based treatment options
- Enhances flexibility in the use of funds, to help state substance abuse agencies:
    - Address service gaps across the continuum of care, including in non-residential settings
    - Promote new approaches and evidence-based models of service delivery
    - Ensure delivery of certain minimum services, including but not limited to individual, group, and family counseling, as well as follow-up relapse prevention services[83]

Attorney General Grants for Justice-Involved Veterans Services and Veterans Courts (Section 502)
No new funding authorization specific to this program.

Allows Attorney General, in consultation with the Secretary of Veterans Affairs, to make grants to establish or expand veterans treatment court programs; peer-to-peer services or programs for qualified veterans; practices that identify and provide treatment and other services to veterans who have been incarcerated; and training programs for criminal justice and behavioral health personnel in serving veterans.

[83] The legislation describes a wide range of potential additional minimum services specific to the needs of the target PPW population, to be determined by SAMSHA's Center for Substance Abuse Treatment (CSAT). See http://nasadad.org/wp-content/uploads/2016/07/CARA-Section-by-Section-July-2016.pdf, page 9, for details.

Plan of Safe Care for Infants (Section 503)

Requires state plans to ensure the safety and well-being of an infant identified as affected by maternal substance use to include addressing the health and substance use disorder treatment needs of the infant and the affected family member or caregiver.

State Demonstration Grants for Comprehensive Opioid Abuse Response (Section 601)
$5M/year ($25M total) for FFY 2017-2021, if appropriated.

Grants to states and combinations of states to implement an integrated opioid abuse response initiative, including:

- Educational efforts
- Comprehensive prescription drug monitoring programs
- Expanding MAT
- Programs to treat and screen individuals in treatment for Hepatitis C and HIV
- Recovery support services in high schools and higher education institutions
- Programs to prevent opiate overdose death
- Raising public awareness of opioid use disorders

Partial Fills of Schedule II Controlled Substances (Section 702)

Allows prescriptions for Schedule II controlled substances to be partially filled, if:

- Not prohibited by state law
- Permitted under federal laws and regulations
- Partial fill is requested by patient or prescriber
- Total quantity dispensed does not exceed the total quantity prescribed

Promoting Abuse-Deterrent Formulations (Section 705)

Changes a definition to support the development and use of abuse-deterrent (including extended-release) formulations of drugs by excluding them from a Medicaid additional rebate requirement.

Pilot Program on Integration of Complementary and Integrative Health for Veterans (Section 933)
No new funding authorization specific to this program.

Requires HHS to establish a pilot program to:

- Assess the feasibility and advisability of using complementary and integrative health and wellness-based programs to complement the provision of pain management and other health care services to veterans.

TO: Councilmember Lisa Herbold, Public Safety and Human Services (PSHS) Committee Chair

FROM: Jesse Rawlins, Public Defender Association (PDA) Public Policy Manager
Mark Cooke, American Civil Liberties Union of Washington (ACLU-WA) Campaign for Smart Justice Policy Director

DATE: September 9, 2020

RE: Project Description for Supervised Consumption Implementation in Seattle

Introduction

This memo was prepared by staff from PDA and ACLU-WA as leading members of the local Yes to SCS Seattle/King County Coalition. The memo defines supervised consumption services, and provides a project description for local SCS operation as an evolution in approach for Yes to SCS. While the original SCS proposal of a stand-alone site was funded by the Seattle City Council in 2017 and 2018 and was approved by the local Board of Health through a 2017 Resolution, previous and current Mayoral administrations have not moved SCS forward. Meanwhile, the economic consequences of the COVID crisis have put massive pressure on the social determinants of health across the board, making extremely costly initiatives that serve a small number of individuals more difficult to support than an approach that can disseminate those services more broadly to populations in need of safer consumption services. If a stand-alone site is not feasible or optimal at the current time, the City should grant the funds through its existing Public Health contract to existing low-barrier social service providers, which can use can those funds for supervised consumption services for their participants.

Background

In 2016, the City of Seattle co-convened with King County the Heroin and Prescription Opiate Addiction Task Force (Task Force). The Task Force provided a Final Report and Recommendations in response to the local opioid epidemic. Recommendations included piloting at least two Community Health Engagement Location (CHEL) sites, one in Seattle and one in King County outside of Seattle, where drug consumption is supervised or made safer in a supportive care setting. This type of programming is also known as supervised or safer consumption spaces or services (SCS). While the Seattle City Council moved this recommendation forward through its budgetary role, and while Mayor Durkan campaigned explicitly on the promise to implement a CHEL site, the City executive departments have not spent the resources or crafted a plan to accomplish this policy goal, resulting in no sanctioned supervised consumption space being operated in Seattle to date.

One stated impediment has been prohibitively expensive cost models. While we do not accept that a SCS site could not be opened and operated with the budget provided by the City Council and King County, we do recognize that the amount of funding called for would, in the short term, benefit a comparatively small number of people, and accept that, in light of the budget pressures and basic needs crisis of the COVID period, it is always best to find ways to accomplish policy goals while serving the broadest number of people possible. To that end, we have consulted with executive leadership for King County and the Seattle Mayor's Office on an alternate route to provide supervised consumption services without the costs attendant to a single stand-alone site. We view this approach as advancing all the stated goals of the 2016 Task Force, in a manner that perhaps better fits the current landscape.

Project Description

Supervised consumption services (SCS) implemented at existing low barrier social service locations is an evolution in strategy for local SCS operation and an acceptable alternative to a stand-alone site that is practiced internationally, is likely to serve more people, and is supported by data. Through its Public Health contract, the City of Seattle's Human Services Department (HSD) can move available SCS funding this year to that contract.

Using that funding, Public Health – Seattle and King County (Public Health) can then provide grants in 2020 to local social service locations that already provide services and support to vulnerable people who use drugs, so that they may add supervised consumption services to existing programming.

Project Benefits

While stand-alone sites are proven successful for public health, researchers released a publication in 2018 demonstrating how co-locating supervised consumption services with a broader service array is also extremely beneficial. As an alternative to a stand-alone site strategy, supervised consumption services can be supplementary features in service locations where unsupervised or unsafe consumption often occurs, not by design but in reality (just as drug use occurs in innumerable single family homes and private apartments). By co-locating supervised consumption services throughout locations in Seattle that house, shelter or serve marginalized drug users, SCS can be integrated to increase support, care and health for vulnerable people who use drugs.

Needs Identification

Local data point to the need for SCS to be implemented as part of the continuum of care for vulnerable people who use drugs. Evidence and data below show various local needs demonstrating SCS as a necessary function for the overall strategy of addressing vulnerable drug use:

- In King County's 2018 HIV/AIDS Epidemiology Report, 80% of surveyed individuals who were participants at Syringe Service Programs (SSP) identified their desire to use supervised or safer consumption. In addition, 39% of those surveyed individuals expressed that they would use SCS on a daily basis.
- Launched in August of 2016, the City's *Sharps Pilot Collection Program* collected 5,365 used and discarded hypodermic needles in public spaces during its first 15-months. Addressing outdoor drug use and subsequently discarded drug equipment is needed, and SCS is one helpful strategy.
- There have been more than 750 overdose deaths inside Seattle to date since SCS funding has been available in 2018. Additionally, countywide data point to 14% of fatal overdoses in 2019 affecting people experiencing homelessness. In comparison, people experiencing homelessness amount to less than 0.5% of the county's entire population; this significantly disproportionate number of overdose deaths involving people experiencing homelessness suggests that SCS services provided for a vulnerable population that is largely homeless is likely a well-targeted intervention to prevent overdose deaths among our most vulnerable population.

Programmatic Outcomes

While the City invests in Syringe Service Programs that make substance use safer, the City simultaneously leaves drug *consumption* unsafe without SCS. While SSPs provide necessary equipment, lack of SCS results in vulnerable people who use drugs with safer equipment but nowhere safer or with supervision to consume. SCS in Seattle will complement and increase efficacy of syringe programs.

A local public health evaluation published in May of 2019 also predicted strong outcomes for SCS practices in Seattle. Using then-current overdose rates, the publication predicted that the SCS pilot would reverse 167 overdoses annually. In addition, the publication's authors found that 45 hospitalizations, 90 emergency department visits, and 92 emergency medical service deployments would be reduced with a piloted SCS, which corresponds to a monetary value of $5,156,019, cost savings that outstrip all projected cost models. The outcome for SCS is a cost-benefit for the City.

Funding Opportunities

Moving the Task Force recommendation for SCS forward and responding to community advocacy, the Seattle City Council allocated $1.3 million in 2018 and an additional $100,000 in 2019 to implement supervised consumption, for a total of $1.4 million. Each funding allocation also included a proviso, and while a report submittal from HSD satisfied the initial proviso while the second proviso has expired.

This year, during the City's Council rebalancing of the City Budget, it was identified that the $100,000 for SCS from the 2019 Green Sheet was errantly omitted from the carry forward ordinance, meaning the two funding allocations needed combining. This was accomplished by City Council approving Amendment 4 to Council Bill 119818 that consolidated the funding into a single Budget Control Level (BCL) in the City's Finance General. Further City Council action is required through legislation to move the totality of funds to HSD's Public Health contract.

Funding Application

In a local public health publication, SCS operations were estimated to be $1,222,332, which is less than what is available with City resources. Those are annualized costs, so it will be important to hold these funds over into 2021 to get full use from this funding pool. Using available funding, specific costs for implementing supervised consumption services could include physically augmenting a space, additional staffing such as a medical provider or peer-support individuals, and harm reduction and drug use supplies, all which can be afforded with available resources.

Budget and Legal Considerations

Not spending available resources for SCS creation, the City's Executive has continuously raised two reasons for not moving forward and spending SCS dollars: budget constraints and legal challenges.

Budget constraints were mainly determined by the stand-alone site model, while the supervised consumption services strategy greatly reduces costs – budget predictions made by the Executive in this memo show more than $5 million for site acquisition and tenant improvements. Tenant improvements of $600,000 can be applicable, but the evolved strategy negates the majority of the identified budget constraints. As previously mentioned, current resources are estimated to be adequate for operating costs based on a local public health evaluation. Suitable providers believe they can accomplish SCS practices within the available budget.

The Executive has also previously identified legal risks for the City, but providing funding for supervised consumption services within existing service providers who serve people that use drugs in low-barrier settings is on strong legal ground, and certainly adds no risk to the existing risk of serving people who use drugs in a low-barrier context. As mentioned, the King County Board of Health passed a Resolution that approved of SCS, and this proposal for embedded supervised consumption services fits squarely within this legal framework. Concerns about federal interference are speculative at best, especially in light of the recent Federal decision in the Pennsylvania Safefouse lawsuit. In addition, City Attorney Pete Holmes signed an amicus brief for the Safehouse legal challenge citing that the Controlled Substances Act does not criminalize public health facilities, which was also ruled by the district court in Pennsylvania. Local jurisdictions have broad authority for regulating matters of public safety and public health.

Conclusion

The majority of the Seattle City Council has either vocalized SCS support or participated in votes to resource SCS. Mayor Jenny Durkan has also publicly supported SCS, during her campaign for Mayor and after taking office, though executive departments have stalled in the face of the estimated cost of a standalone site. The Yes to SCS Coalition, staffed by our organizations, has evolved a viable alternative strategy for spending City resources for supervised consumption, but this path still requires City Executive action.

Like the Mayor and Council, Seattle community members also overwhelmingly support SCS. A November 2019 poll found that 61% of voters continued to support this type of project. With elected and community support, substantial needs for community safety and individual health, as well a clear path to resolving challenges, City Executive action for allocating available funding to the Public Health contract is necessary.

Public Health
Seattle & King County

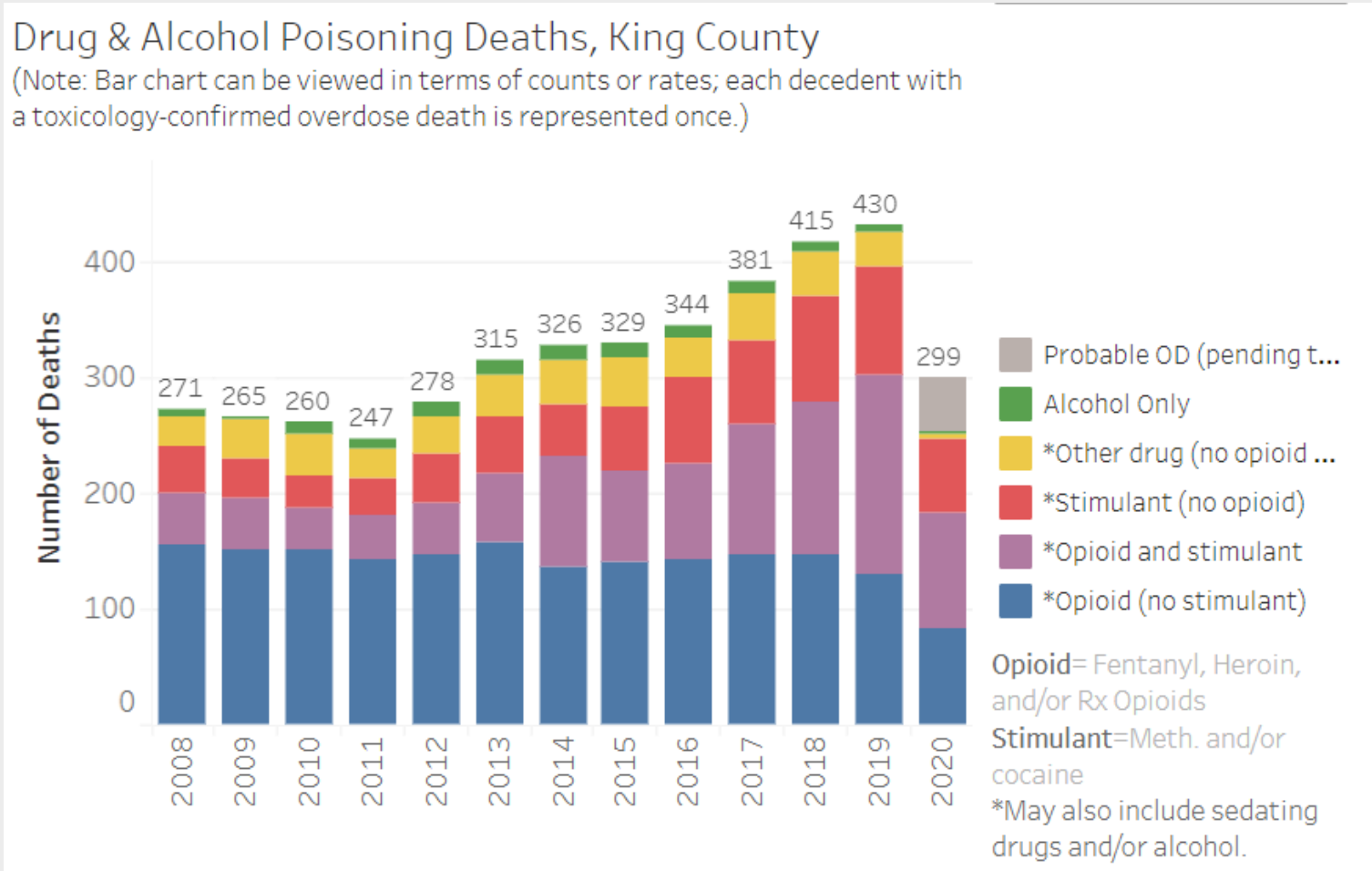
Overdose Update

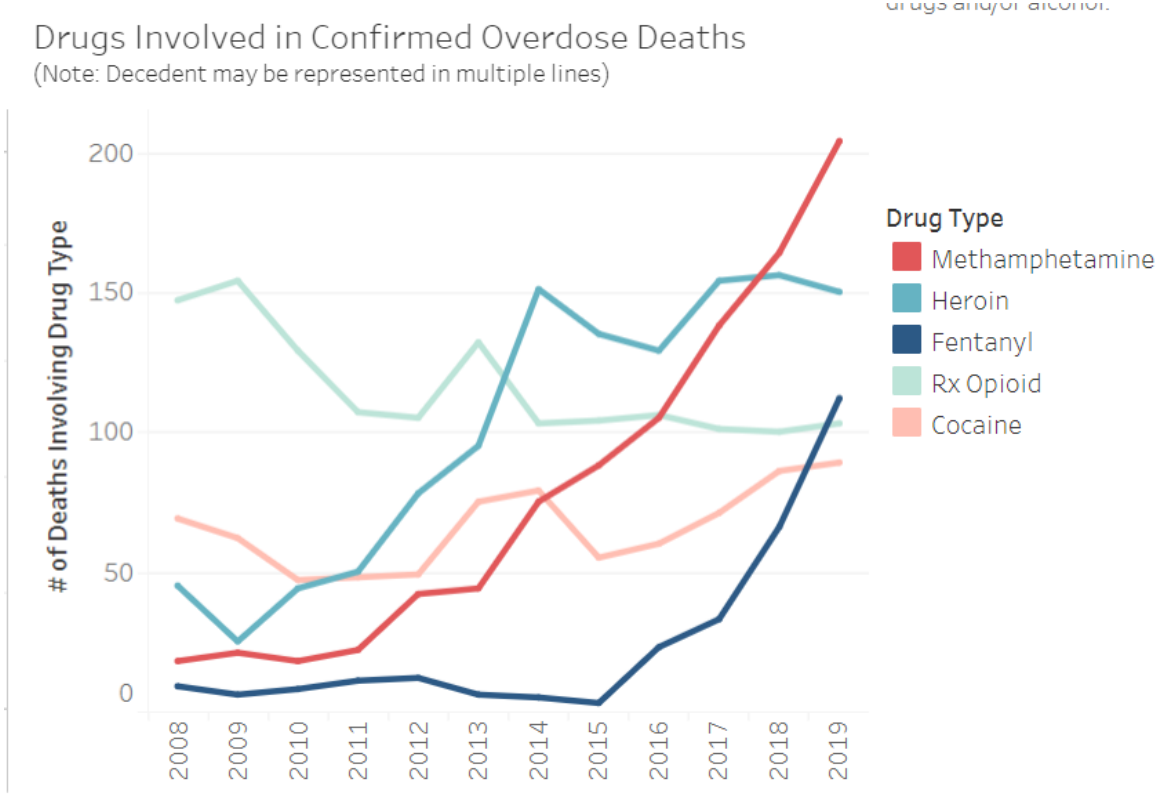
Brad Finegood
Strategic Advisor
Public Health - Seattle &
King County

9-22-2020

Seattle City Council

Overdoses continue to rise every year.





Complexity continues to evolve.

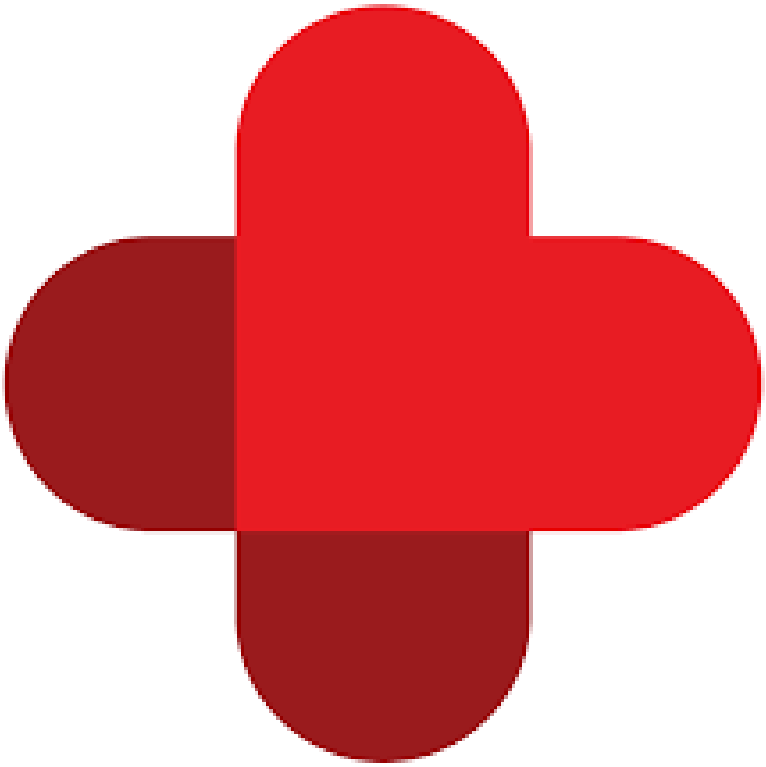
Geographic Impacts of Overdose Deaths (2019-2020)

King County Location of Overdose Death	Fentanyl	Non-Fentanyl
Seattle	41%	55%
Rest of County	59%	45%

YES TO SCS—

Yes to Safe Consumption Spaces – Seattle/King County

a presentation on local strategies for implementing SCS



Seattle City Council
Public Safety and Human Services Committee
September 22, 2020

Yes to SCS is a Project with Public Defender Association (PDA)

YES to SCS Presentation

- Coalition member introductions
- Yes to SCS timeline
- Local strategy for SCS implementation
- SCS legal landscape
- Health care perspective for local SCS strategy
- Service provider perspective for local SCS strategy
- Questions and comments

Coalition Member Introductions

Lisa Daugaard – Public Defender Association (PDA) Director

Jesse Rawlins – Public Defender Association (PDA) Public Policy Manager

Mark Cooke – American Civil Liberties Union of Washington (ACLU-WA) Campaign for Smart Justice Policy Director

Michael Ninburg – Hepatitis Education Project (HEP) Executive Director

Lisa Etter-Carlson – Aurora Commons Co-Founder

Yes to SCS Timeline

2016

Heroin and Prescription Opiate Addiction Task Force Recommendations

Yes to SCS Coalition

2017

Board of Health Resolution

2018

City of Seattle FAS / HSD Memo

Seattle City Council Budget Action One

State Supreme Court Blocks Initiative I-27

2019

Seattle City Council Budget Action Two

2020

Seattle City Council Budget Action Three

Local SCS Strategy

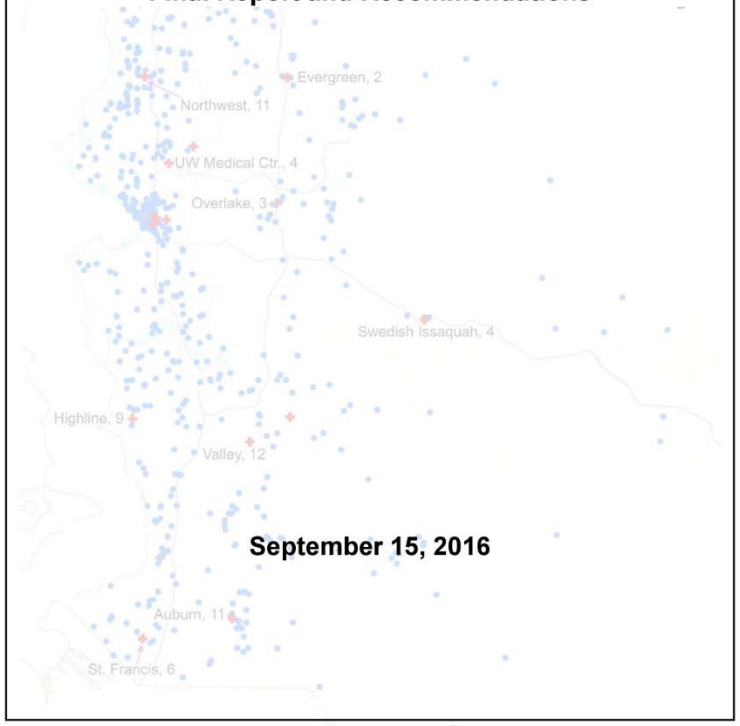
Local Strategy for SCS Implementation

Supervised consumption services (SCS) implemented at existing low barrier social service locations is an evolution in strategy for local SCS operation and an acceptable alternative to a stand-alone site that is practiced internationally, is likely to serve more people, and is supported by data.

SCS Legal Landscape

Heroin and Prescription Opiate Addiction Task Force

Final Report and Recommendations



September 15, 2016

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA, **Plaintiff,**	:	**CIVIL ACTION** **No. 19-0519**
v.	:	
SAFEHOUSE, a Pennsylvania nonprofit Corporation; JOSE BENITEZ, as President and Treasurer of Safehouse, **Defendants.**	:	
SAFEHOUSE, a Pennsylvania nonprofit Corporation, **Counterclaim Plaintiff,**	:	
v.	:	
UNITED STATES OF AMERICA, **Counterclaim Defendant,**	:	
and	:	
U.S. DEPARTMENT OF JUSTICE; WILLIAM P. BARR, in his official capacity as Attorney General of the United States; and WILLIAM M. McSWAIN, in his official capacity as U.S. Attorney for the Eastern District of Pennsylvania, **Third-Party Defendants.**	:	

McHUGH, J. **FEBRUARY 25, 2020**

MEMORANDUM

This case arises out of Defendant Safehouse's proposal to open a safe injection site in Philadelphia to mitigate the harms resulting from unlawful opioid abuse, and the Government's determination that opening such a site would be unlawful. Previously, I denied a motion for judgement on the pleadings filed by the United States. ECF 134. In doing so, I concluded that,

No. 20-1422

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

UNITED STATES OF AMERICA,
Appellant,

v.

SAFEHOUSE, a Pennsylvania nonprofit corporation; JOSE BENITEZ, as President and Treasurer of Safehouse,
Appellees.

SAFEHOUSE, a Pennsylvania nonprofit corporation,
Appellee,

v.

U.S. DEPARTMENT OF JUSTICE; WILLIAM P. BARR, in his official capacity as Attorney General of the United States; AND WILLIAM M. MCSWAIN, in his official capacity as U.S. Attorney for the Eastern District of Pennsylvania,
Appellants.

On Appeal from the United States District Court for the Eastern District of Pennsylvania in Case No. 2:19-cv-00519, Judge Gerald A. McHugh

BRIEF FOR AMICI CURIAE CURRENT AND FORMER PROSECUTORS, LAW ENFORCEMENT LEADERS, AND FORMER DEPARTMENT OF JUSTICE OFFICIALS AND LEADERS IN SUPPORT OF APPELLEES AND AFFIRMANCE

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(617) 526-6000

July 6, 2020

ADDITIONAL COUNSEL LISTED ON INSIDE COVER

Health Care Perspective for Local SCS Implementation

- Increase service effectiveness
- Continuum of care
- Mitigating unsafe consumption

Service Provider Perspective for Local SCS Implementation

Currently across Seattle, unsafe or unsupervised drug consumption occurs in social service locations that provide services to vulnerable people who use drugs.

Final questions and comments

Legislation Text

File #: Inf 1689, **Version:** 1

Co-LEAD Presentation

Adapting LEAD for the COVID-19 crisis & beyond to test new models of care paired with hotel-based temporary housing.

Co-LEAD is a temporary adaptation of the Law Enforcement Assisted Diversion (LEAD) program in Seattle and Burien, during the COVID-19 emergency period. "Co-"stands Community, COVID and Co-Responder.

Public Safety Briefing with Seattle City Council, September 22, 2020

By: **The Public Defender Association**

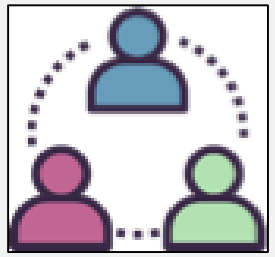
Jesse Benet, Deputy Director and Co-LEAD Project Director - Tab Davis, Ops Manager/Lodging Liaison - Ramon Hernandez, Shift Lead

Co-LEAD—born as a variant of LEAD

est. March 2020

- Co-LEAD is running in parallel with standard LEAD operations, which have been constrained under COVID conditions and lack of law enforcement availability (and our national social movement to reduce LE overall) affecting all partners—while need has only increased
- Co-LEAD participants sign the same Release of Information that LEAD participants do, allowing **coordination and information-sharing** criminal legal system partners when needed to address any open court cases and outstanding warrants
- Co-LEAD provides **viable channels** to intercept the population LEAD is intended to serve—people with behavioral health conditions (often living unhoused) who have exposed to enforcement and the criminal legal system
- Co-LEAD applies LEAD core principles of coordination, information-sharing, field-based engagement, is trauma responsive, Housing First, harm reduction and crime reduction

What is Co-LEAD?



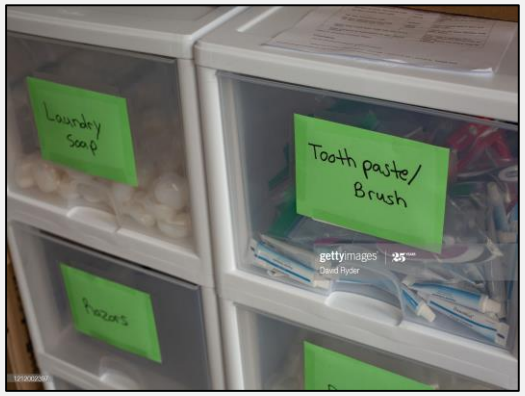
- Co-LEAD has a team of temporary team of **intensive outreach responders** and case managers, along with a medical provider. Outreach responders work the following **shifts** *Each shift has a shift lead who supervises the team of outreach responders assigned to geographic region (based on hotel locations)*

  - M-F 8 am to 4:30 pm & 11 am to 7:30pm
  - Sat & Sun: 10 am to 4:30 pm
  - Overnight on-call shift lead/supervisor availability

- Co-LEAD currently uses **hotels throughout King County** to place participants to shelter in place and reduce. Additional hotel rooms are utilized for staff office space and during each shift to fully support an on-site presence similar to a residential setting.

  - Each participant signs the **Co-LEAD Lodging Agreement** which defines the rules of the lodging and participant requirements
  - Co-LEAD has PDA staff who serve as **lodging liaisons** between hotel staff and Co-LEAD outreach responder program staff (modeled after landlord liaison approach in permanent supportive housing models)

What is Co-LEAD (cont'd)



- Co-LEAD reduces crime and helps stabilize vulnerable individuals by addressing the **basic needs** of Co-LEAD participants, using gift cards, providing cell phones, access to food, sanitation supplies, and crisis management needs

- Co-LEAD provides **intensive case management** connecting participants to Apple Health, entitlements/benefits (DSHS/SSA), obtain ID, and connect to other social services available (behavioral health, primary care, employment)
  - Co-LEAD focuses on the temporary nature of the lodging and works to support participants for longer-term housing and support plans

- **Co-LEAD medical provider** provides assessment of healthcare needs and related care including prescription and pharmacy coordination
  - Goes on-site to hotels with outreach responders to provide field-based healthcare assessment and response (incl Apple Health, prescription mont.)
  - Provides **Covid-19 testing** immediately upon program entry and on demand if symptoms or possible exposure occurs
  - Rapid connection on-site to primary care clinics for Medication Assisted Treatment

CO-LEAD EARLY LESSONS LEARNED

CURRENTLY 68 PARTICIPANTS ENROLLED

- **Lodging (M/Hotel) liaisons** are KEY!
- **Temporary Lodging Agreement:** ensure full understanding
- **Meal delivery/Food strategies:** support food insecurity
- **Medical provider:** provide on-site assessment (primary care and behavioral healthcare) and care at m/hotels
- **Harm reduction oriented protocol for unique Meth users:** provide responsive support (and possibilities of a Stimulant Substitution Therapy/Safe Supply version of MAT)
- **LEAD Prosecutorial liaisons:** critical for understanding the whole picture of those referred to ensure matching with services (conviction history, open court cases, outstanding warrants)
- **Incentives to support financial independence:** support participant needs/reduce law violations
- **Diverse staff:** backgrounds and expertise/knowledge including deep lived experience
- **Medicaid-funded behavioral health system**: Limitations (and frustrations!) especially during Covid-19

CO-LEAD: A DEVELOPMENTAL EVALUATION

Katherine Beckett, Professor

University of Washington

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EARLY STEPS

- ✓Adapted interview protocol used in the Riker's Island Jail Reentry Study (Columbia University)
- ✓Human Subjects approval from the UW
- ✓Grant support for the UW West Coast Poverty Center

- ✓Created the UW research team
  - Emily Soran-Knaphus, PhD in Sociology, Research Scientist
  - Aliyah Abu-Hazeem, PhD student in Sociology
  - Marco Brydolf-Horwitz, PhD student in Sociology
  - Devin Collins, PhD student in Sociology
  - Allison Goldberg, PhD student in Sociology

DEVELOPMENTAL EVALUATION

- Developmental evaluation (DE) supports innovation by collecting and analyzing data in real time in ways that facilitate informed decision making
- DE is particularly well-suited for new innovations for which the path to success is not clear

DE can help answer questions such as:

- What is emerging as the innovation takes shape?
- What do initial results reveal about expected progress?
- What variations in effects are we seeing?
- How have different values, perspectives, and relationships influenced the innovation and its outcomes?

STATUS OF DATA COLLECTION

DATA COLLECTED (JUNE –AUGUST 2020)	DATA TO BE COLLECTED (SEPTEMBER 2020- MARCH 2021)
• 37 first-round participant interviews	• Exit interviews (participants)
• 30 follow-up interviews	• Interviews with staff and leadership
• On-going observation of staff and stakeholder meetings	• Interviews with community stakeholders/partners
• On-going collection and analysis of administrative data	• Continued collection and analysis of administrative data

HIRING CO-LEAD OUTREACH RESPONDERS AND SHIFT LEADS

- Job listings were shared with organizations that would reach a diverse group of people with lived experience with addiction, homelessness, and the criminal legal system.
  - These organizations include Community Passageways, REACH, Formerly Incarcerated College Graduates Network, Formerly Incarcerated Student Association at UWT, Husky Post-Prison Pathways, and Civil Survival
- As a result, applicants and hired outreach responders
  - Have had significant life experience with behavioral health issues, criminal legal system involvement, and/or homelessness
  - Are racially, ethnically, and culturally diverse

CO-LEAD PARTICIPANTS

Gender	
Female	25.7%
Male	74.3%

Race/Ethnicity	
American Indian/ Alaska Native	13.6%
Asian	1.5%
Black	37.9%
Latinx	4.5%
White	40.1%
Unknown	1.5%
Percent BIPOC	58.4%

Age	
Average	40 years old
Range	22-62

- All but one were living unsheltered prior to entering Co-LEAD
- All have or have had substance abuse issues
- At least 25 have a mental health diagnosis and/or prior psychiatric hold
- Many face significant physical health challenges

Services and Accomplishments to Date	
Intensive case management	66/66
Housing	65/66
COVID-19 testing	66/66
(Re)enrolled in Apple Health (Medicaid)	60/66
Housing assessment completed	12/66
Connected to behavioral health services	11/66
Medication assisted treatment	12/66
Job placement	11/66
Obtained DSHS benefits	9/66
Permanent housing secured	2/66
* *Data current through August 31, 2020*	

EARLY INTERVIEW THEMES

HOUSING

- Most Co-LEAD participants expressed a newfound sense of safety and security after being placed in their own hotel rooms.

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- *"It's like going from hell to heaven."*

- *"There's no arguments, no fights, no gun shots, no police sirens, ambulance sirens."*

- *"Above all things, it's a stable environment that's mine. I don't have to worry about dealing with other people. […] I'm glad that I have a place that I can call my own, that I can sleep in and be safe. And it gives me stability and peace of mind where I can better my future."*

OUTREACH RESPONDERS

- Co-LEAD outreach responders were described by many as being supportive, reliable, and willing to go "above and beyond."

- Many respondents noted that Co-LEAD outreach responders had shared lived experiences and felt that this enabled them to approach casework in a nonjudgmental and "down to earth" manner.

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"Co-LEAD, the counselors... they care. You can tell that they're not self-seeking. They want to help us. That makes me open up more."

"It's just kinda nice to have a case worker that knows so little about me but I feel like I've known him forever, if that makes sense. He's got a lot of the same lifestyle, not that I had, but similar. He was homeless at one time. And now he works for Co-LEAD. And I'm just like, man, if you can do it, we can. He's an inspiration to me."

SERVICES AND BENEFITS

- Many interviewees report that Co-LEAD has improved their ability to access public services and benefits.
  - Many credited their outreach responders for helping to navigate the "bureaucratic hoops" and being their "advocate."
  - Consistent access to a phone, internet, and mailing address made basic outreach to and follow-up with social service agencies possible.

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"I've had food stamps for about 2 years, something like that, 2-3 years. Getting them was easy. I did it in-person first, and then I had a mid-certification review come up, and they were closed because of the COVID thing, so that sort of messed things up for me. But my case manager helped me get ahold of somebody on the phone and they had my card mailed within the next 2-3 days, along with not only the food stamps but the disaster relief money too."

HEALTH CARE

- Interviewees consistently report that Co-LEAD improved their ability to access needed health care.
  - Co-LEAD outreach responders support participants in scheduling and keeping doctors appointments, and an on-site naturopath provides swift, accessible, and consistent care.

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"I'm not using street drugs to manage my ADHD and my dyslexia. I'm working with [a] psychologist and a psychiatrist and a naturopathic kind of solution to deal with that. And I think that's wonderful."

"I slept on a slight incline and I ended up sleeping on my knee wrong a few times and injuring it, to the point where it just got difficult. So thankfully, when I came back [Co-]LEAD hooked me up with the doctor, and they were able to get me some anti-inflammatory so I can begin the healing process on it again. But I'm finally active now and moving again, which is really nice."

SUBSTANCE USE

- Some participants are not currently working on reducing substance use, but have modified behavior to reduce harmful impact
  - Some stopped using or entered treatment before entering Co-LEAD
  - Others are not interested in or do not feel capable of reducing their substance use at this time
- Other participants are attempting to reduce or eliminate their use of drugs
  - Often these participants see getting clean as a means of addressing other priorities like being reunited with their families

THREE FACTORS SEEM TO HELP PEOPLE REDUCE THEIR DRUG USE

Access to MAT is helping some to address their substance use

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"Before I got hooked up with Co-LEAD, like I said it was rough. I was living on the streets. And it was, uh, it wasn't very good at all. I wasn't being very healthy, I wasn't making doctors appointments. I am now. And they've helped me get on Suboxone. They've really been looking out for me… I've cut back on my drug use… I don't like [Suboxone] that much, but it helps. Helps with cravings."

Stable housing and support have also been key for some

***

*"[Life before Co-LEAD] was not very good. I was doing a lot of heroin and meth and stuff. I was going to jail pretty frequently, cuz I was doing like burglaries and robbing buildings and all this extra s***. And it was not good. And so Co-LEAD has really helped me stay sober and I've been sober for like two months or whatever, and like, it's really good. So I'm really proud of myself."*

FUTURE QUESTIONS TO EXPLORE

- For participants who are able to achieve their goals, what particular features of Co-LEAD were most helpful?
- For participants who are unable to achieve their goals, what obstacles prevented this from occurring?
- What do staff and stakeholders see as the most important lessons learned?
- What was the experience of community partners/stakeholders who sought assistance from Co-LEAD, and can this be improved?

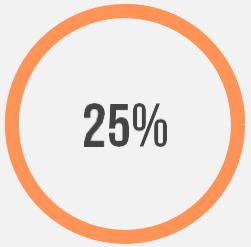
ADDRESSING BEHAVIORAL HEALTH WITHOUT POLICE?

Findings from the Seattle LEAD/Co-LEAD Program

FORREST STUART | DEPARTMENT OF SOCIOLOGY | STANFORD UNIVERSITY

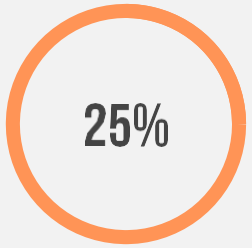
WHY FOCUS ON BEHAVIORAL HEALTH?

OF PEOPLE KILLED BY POLICE ARE PEOPLE EXPERIENCING DISABILITIES

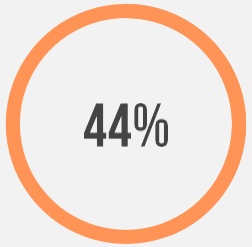


OF PEOPLE KILLED BY POLICE ARE EXPERIENCING MENTAL HEALTH DISORDERS

OF POLICE ENCOUNTERS INVOLVE PEOPLE EXPERIENCING MENTAL HEALTH DISORDERS



OF INMATES COMMITTED OFFENSE TO OBTAIN MONEY FOR DRUGS



OF JAIL INMATES EXPERIENCE MENTAL HEALTH DISORDERS

DRUG POSSESSION IS THE MOST ARRESTED CRIME IN THE US, OCCURRING EVERY 25 SECONDS

The current state of reforms

1 Basic mental health training for officers

6.5 hours in academy, 1 hours in-service

Topics range from dementia to drug use

2 Crisis Intervention teams (CIT) / memphis model

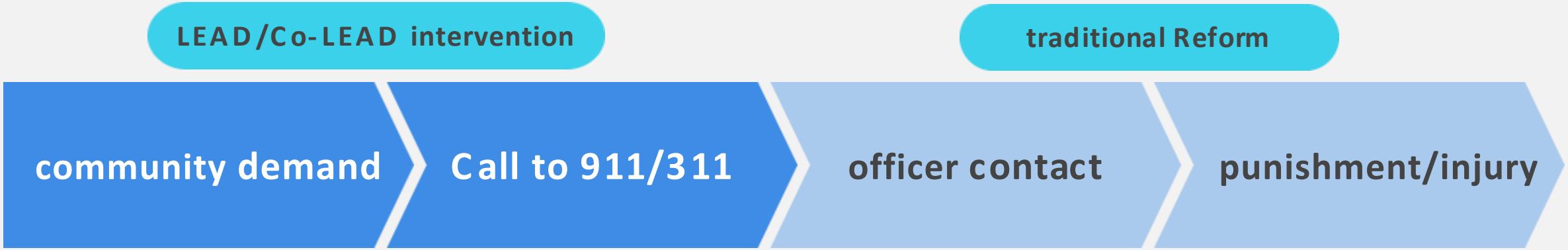
40 hours training for officers as first responders

Officers access additional resources for referrals

These Reforms Fail to reduce harm/injury to vulnerable populations

These reforms increase/expand policeability of behavioral health

moving further“ upstream”



providing proactive services

1. **Solicit "priority lists" from local police precincts**

   Locate and initiate services with individuals on the list

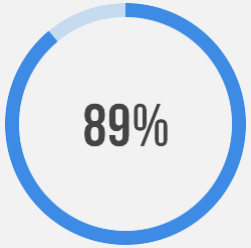
2. **Solicit "priority lists" from local residents and businesses**

   Locate and initiate services with individuals on the list

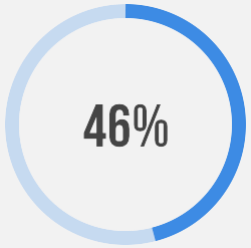
3. **provide alternative complaint system**

   Stakeholders contact LEAD directly when encountering people in acute crisis/law violation

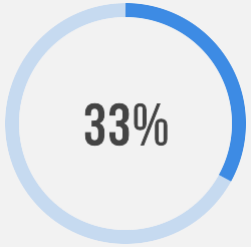
LEAD PARTICIPANT OUTCOMES



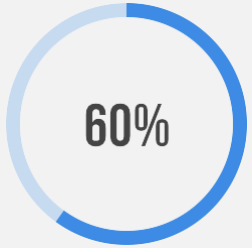
MORE LIKELY TO OBTAIN PERMANENT HOUSING



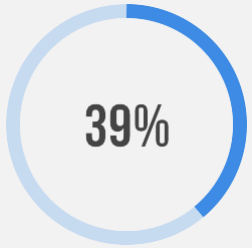
MORE LIKELY TO BE ON EMPLOYMENT CONTINUUM



MORE LIKELY TO RECEIVE BENEFITS (E.G., SSI, DISABILITY)



LESS LIKELY TO BE ARRESTED



LESS LIKELY TO BE CHARGED WITH A FELONY

41 FEWER DAYS IN JAIL = $6,000 YEARLY COST REDUCTION PER PERSON

Thank You!

Any Questions?